THE CANADIAN NURSE

ME 51 • NUMBER 2
MONTREAL

Highlight for
BRUARY 1955

URSING SERVICE BUDGET

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

Subscription Rates: Canada & Bermuda: 6 months, $1.75; one year, $3.00; two years, $5.00.
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Department of National Health and Welfare,
Ottawa, Ontario.

Between Ourselves

As an active member of the Halifax Branch of the Victorian Order of Nurses since 1940 and district director for more than 10 years, **Jean Stewart Forbes** had contributed in no small measure to the developments in nursing in Nova Scotia long before she assumed the presidency of the provincial association in 1953. She continues to give a quality of leadership that presages new strengths for the profession.

Born in St. John's, Nfld., of Scottish parents, Miss Forbes moved with her family to New Glasgow, N.S., while in high school. She received her training in nursing at the Civic Hospital, Ottawa, then qualified for her certificate in public health nursing at the McGill School for Graduate Nurses. She joined the V.O.N. immediately and was attached to the Montreal Branch prior to her transfer to Halifax. Miss Forbes secured her B.Sc. from Teachers College. An ardent student of natural history, she revels in discovering new beauty spots in the province by the sea.

* * *

That women, from time immemorial, have come "to the rescue" in many crucial times is a well known fact. That they will continue to do so is a foregone conclusion. **Lillian Campion** describes for us the special training for rescue work that a selected group of women received in connection with the developing civil defence program. Though it was strenuous the participants really enjoyed themselves hugely. And they demonstrated beyond any question that even in this atomic age women are capable of amazing feats of physical strength.

* * *

Budget preparation is always a headache whether it is for one's personal finances or for a large organization. The old maxim — "overestimate expenditures and underestimate income" — may be satisfactory for the nurse who is juggling with the problem of making ends meet and at the same time making enough for that long-cherished trip. (By the way, have you started to save yet for your trip to Rome in 1957 for the Congress of the International Council of Nurses?) The harassed director of nursing, however, will find practical assistance in the excellent exposition of this whole topic prepared by one who has learned how to do by doing — **Edith Young.** The information is so simply yet completely outlined that the beginner will find help, the experienced director some new ideas.

* * *

Another very practical and helpful idea is the ward manual described by **Marjorie Hewitt.** She notes the difference between the kinds of material included in this manual and the procedure book customarily found on the ward. This new variety of manual should prove very helpful to new staff members.

* * *

Nearly nine years ago — April, 1946, to be exact — the pages devoted to articles for our French-language members became a regular feature of the *Journal.* Three months later the translation of the releases from our National Office was started. Every line of that translation, over all these years, has been prepared by **Suzanne Giroux,** official visitor to the French schools of nursing in the Province of Quebec. Most of the articles have been secured through her requests. We are profoundly grateful to Miss Giroux for her truly amazing contribution of time and translating skills.

This month, we are introducing another feature. So much of the literature of nursing, of medical science, is a closed book to the large number of our French nurses who have little or no comprehension of English. In an attempt to overcome this barrier, our new page, "Sélections," will contain translations of condensed articles from contemporary periodicals. Miss Giroux hopes to secure the assistance of some of her colleagues in the preparation of these abstracts. Are there any volunteers?

* * *

This is the 584th issue of *The Canadian Nurse* to come off the presses. Started as a quarterly magazine in March, 1905, the *Journal* has been published every month since January, 1907. Millions of words, thousands of authors later, our *Journal* will be celebrating its **Golden Anniversary** next month. To mark this occasion, an extra special issue is in the making, complete with a ***golden*** cover. No Canadian nurse will want to miss seeing this anniversary number. Order your copy right now if you are not a regular subscriber. Though the usual price per copy is 35 cents, a charge of 50 cents will be made for single copies of this anniversary issue.

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New Products

Edited by **DEAN F. N. HUGHES**

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ANCAZINE

Manufacturer: Anglo-Canadian Drug Co. Ltd., Oshawa, Ont.

Description: Each cc. of syrup contains piperazine citrate in an amount equivalent to 100 mg. of piperazine hexahydrate.

Indications: For eradication of pinworms in both adults and children.

Administration: Treatment should be continued for 7 days and repeated after one week. Administer half the daily dose in the morning and half at night:

Children: up to 15 lbs., ½ teaspoonful daily; up to 30 lbs., 1 teaspoonful daily; up to 60 lbs., 2 teaspoonfuls daily; over 60 lbs., 4 teaspoonfuls daily.

Adults: 4 teaspoonfuls daily.

BENACINE TABLETS

Manufacturer: Parke, Davis & Company, Ltd., Walkerville, Ont.

Description: Sugar-coated tablets, each containing: Benadryl hydrochloride (diphenhydramine hydrochloride) 25 mg., and hyoscine hydrobromide, 0.325 mg.

Indications: Of value in combating the effects of motion sickness, (air sickness, seasickness, car sickness), and in the treatment of Parkinson's syndrome.

CYCOTIN

Manufacturer: Reed & Carnrick Ltd., Toronto.

Description: Each tablet contains: Methylcellulose 500 mg., d-amphetamine phosphate 2.5 mg.

Indications: For adjunctive treatment of obesity.

Administration: Two tablets with full glass of water 3 times daily, one-half hour before meals.

DOMICONE CREME

Manufacturer: *Can. Dist.:* Professional Sales Corporation, Montreal.

Description: 20% silicone (dimethylpolysiloxane) in an acid mantle creme base. pH 4.0.

Indications: For coating the skin with a protective film against external irritants.

Administration: Rub freely into skin that is to be exposed.

DULSANA COMPOUND

Manufacturer: Charles E. Frosst & Co., Montreal.

Description: Each 5 cc. teaspoonful contains: Paracarbinoxamine maleate 2 mg., ephedrine hydrochloride 4 mg., codeine phosphate 10 mg., ammonium chloride 100 mg., chloroform 25 mg., menthol 0.25 mg., flavored syrup base q.s.

Indications: For the symptomatic relief of cough in pharyngitis, laryngitis, tracheitis, bronchitis, pneumonia, bronchiectasis, bronchial asthma, whooping cough, smoker's cough and the "cough habit of nervous origin."

Administration: Adults: One or two teaspoonfuls three or four times daily, as required. Children: 6-12 years: one-half to one teaspoonful three or four times daily, as required: children under six years as recommended by the physician.

EBSONE-F OINTMENTS

Manufacturer: E. B. Shuttleworth Limited, Toronto.

Description: EBSONE-F 2½% containing hydrocortisone acetate 2½%, neomycin sulphate ½%.

EBSONE-F 1% — containing hydrocortisone acetate 1%, neomycin sulphate ½%.

Indications: For general use in eye injuries and skin inflammations, in eczema, pruritus ani and vulvae, contact dermatitis, neurodermatitis.

Administration: Apply thinly to affected area one to three times a day.

FERROID PLUS

Manufacturer: Carter, Cummings & Co., Ltd., Windsor, Ont.

Description: Each capsule contains: Ferrous gluconate 5 gr., thiamine mononitrate 0.5 mg., riboflavin 0.15 mg., niacinamide 7.5 mg., vitamin B_{12} 10.0 mcg., folic acid 1.0 mg., liver fraction 2 N.F. 75.0 mg., gastric mucosa 75.0 mg., ascorbic acid 50.0 mg.

Indications: For the treatment of anemias due to inadequate nutrition and other causes, metabolic disorders, pregnancy and post-partum, and as supplementary therapy in pernicious and certain megaloblastic anemias.

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Indications: Menopausal syndrome and other forms of hypoestrinism amenable to estrogenic therapy.

Administration: *Suggested dosage schedule:* Initially one tablet daily. Increase to 2 or 3 tablets as required to relieve primary symptoms, then reduce to maintenance level suitable for individual case; or start with 3 tablets daily in single or divided dose, and reduce to one tablet daily when symptoms subside.

NAREMIDE

Manufacturer: Sharp & Dohme (Canada) Ltd., Toronto, Ont.

Description: Each dry-filled, red and white capsule contains: Salicylamide 0.225 gm., phenacetin 0.15 gm., caffeine 30 mg., propadrine phenylpropanolamine HCl 25 mg.

Indications: For the relief of nasal congestion and other symptoms of coryza, grippe, rhinitis, sinusitis, and nasopharyngitis.

Administration: *Average adult dose:* one capsule 4 to 6 times daily (not to exceed 6 capsules in 24 hours). *Children (6 to 10 years):* One 3 to 5 times daily (not to exceed 5 capsules in 24 hours). *Children (3 to 5 years):* One 2 or three times daily (not to exceed 3 capsules in 24 hours).

PAMIPHEN Elixir

Manufacturer: The Upjohn Company of Canada, Toronto.

Description: Each 5 cc. contains: Pamine 1.25 mg., phenobarbital 8.0 mg.

Indications: Chronic hypertrophic gastritis, pylorospasm, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine, spastic colon, mucous colitis, diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis and anxiety.

Administration: Adults, one teaspoonful 3 or 4 times daily (before meals and at bedtime). Children over 4 years, ½ teaspoonful 2 or 3 times daily before meals.

SENEMA Suppositories

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Indications: For the treatment of coughs, colds and bronchitis in children.

Administration: One fluid drachm or in proportion to age.

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THE CANADIAN NURSE
L'Infirmière Canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 51 NUMBER 2

MONTREAL, FEBRUARY, 1955

Nova Scotia Keeps Faith

IT HAS BEEN SAID "that change is the law of life and that to cope with changes adequately is a challenge to the living." In meeting this challenge, the assistance and support of all within the profession and many without it is necessary in order to meet these changes that affect our profession and consequently our nursing service to the public.

Most of the changes which we are now experiencing in Nova Scotia have been brought about or recognized, modified or accepted, as a result of past and present efforts of all those members of our profession and their friends who have contributed their time and effort in a cooperative way. The results of some of these past efforts are seen in many tangible ways. To indicate only a few, we might mention the establishment of the Dalhousie School of Nursing in 1949, the revision of the R.N.A.N.S. Act in 1950, the completion of the proposed Curriculum for Schools of Nursing in 1951, the adoption of the Recommended Personnel Policies for nurses in 1954.

The Registered Nurses' Association of Nova Scotia Act contains some rearrangements and clarification of provisions contained in the previous Act of 1931. Provision has been made for a shortened course in nursing education. Communicable diseases and tuberculosis nursing have been added to the curriculum as well as psychiatric nursing for male nurses. Schools of nursing, as well as meeting the requirements set out in the Act, have to be approved by the Executive Committee

Myers Studio

JEAN S. FORBES

of the R.N.A.N.S. The age of registration has been lowered from 22 years to 21 years. Provision has been made for honorary and associate membership and for a School of Nursing adviser. For this position we were pleased to obtain the services of Miss Rhoda MacDonald.

The School of Nursing adviser's report shows a more favorable record of health among student nurses. Another progressive step concerns the use of the test pool system of registration examinations which will be undertaken in 1955.

Federal bursaries are being given annually to the personnel of voluntary hospitals for post-graduate training. This development resulted from the Brief that was presented by the R.N.A.N.S. to the Government asking for bursaries. The provincial Department of Health continues to allocate Federal bursaries for post-graduate students in teaching and public health.

Through the provincial government committee on Maternity and Child Hygiene, supported by Federal Health Grants, plans are being made for improvement in the maternity program in Nova Scotia. One of the projects in the plan is a short refresher course in obstetric and pediatric nursing. Opportunity has been afforded the nurses, taking these refresher courses, to observe the latest developments in the maternal and child care program through the facilities of Dalhousie University and cooperating institutions and agencies.

As part of the Medical Services Survey of Nova Scotia undertaken by the provincial Department of Health through the Federal Health Survey Grant, a survey to determine the nursing requirements and to establish a plan to meet these requirements was conducted in 1950. These surveys were conducted by Dr. C. B. Stewart and Miss Electa MacLennan of Dalhousie University. The result showed a need for more nurses, both professional and auxiliary. Recommendations were made concerning various phases of nursing including student facilities and educational needs, staffing of hospitals, personnel policies, equipment, education of the student nurse and government assistance.

An Act governing the training and registration of nursing assistants, introduced by the Department of Health, is now in force. Nursing assistants are being trained at Camp Hill Hospital, Halifax, under the D.V.A. The R.N.A.N.S. has a representative on the Registration Board for Nursing Assistants.

Our association has taken an active part in the Civil Defence program and has cooperated with authorities in the program for training of all registered nurses and auxiliary nursing personnel in nursing aspects of A.B.C. Warfare. Recently a survey has been made of all nursing personnel in the province by the Civil Defence Committee of the Association.

We are happy to note an increase in qualified people in teaching positions in our schools of nursing. Nursing education throughout the province is showing considerable improvement since the setting up of a curriculum, the employment of a school of nursing adviser and the establishment of the School of Nursing at Dalhousie University.

The fact that a university school of nursing is functioning actively has stimulated interest in the various post-graduate courses offered as well as making available more trained personnel. The various agencies in the community who participate in the student field work program gain by the contact with the students and the School. The School contributes much to the educational life of the province. The directors are active in executive positions in the R.N.A.N.S. and participate in committee and community work as well as acting in a consultant capacity to those seeking assistance.

The Association, for the past four years, has annually awarded the sum of $100 to a student of the Dalhousie University School of Nursing on the basis of general proficiency and progress. The award is known as the Lenta G. Hall Memorial Award in recognition of Miss Hall's successful efforts through the Association to establish this school.

Changes bring with them new adjustments, new attitudes and new activities in the profession. It behooves each of us to use our skill, integrity,

vision and intelligence in shaping the nursing profession of the future so that it shall continue to stand for those high principles of service which have been passed down to us through the years.

JEAN S. FORBES
President, Registered Nurses' Association of Nova Scotia

Women to the Rescue

F. LILLIAN CAMPION

Editor's Note: Miss Campion was recently invited to attend a special civil defence course as official representative of the Canadian Nurses' Association. Below, she relates some of her impressions of and reactions to this important course.

MOST NURSES are familiar with the role they will be called upon to play in civil defence. However, it has become apparent that there are many important emergency functions that can be performed by *all* women. Among the duties with which women would naturally ally themselves are: casualty care, emergency feeding, distribution of clothing, provision of shelter, maintenance of communications, monitoring, fire fighting and basic rescue.

That they are capable of taking part in almost any service was amply demonstrated by about 50 Canadian women in a special civil defence course given recently at the Federal Civil Defence College in Arnprior, Ontario. This group, representing women's organizations from across Canada, included housewives, newspaperwomen, secretaries, teachers, a Salvation Army officer, an alderman and a policewoman. Their ages ranged from 20 to 60. There were eight nurses among the group.

Miss Campion is nursing service secretary of the Canadian Nurses' Association.

All pictures in this article are used through the courtesy of the Department of National Health and Welfare.

Our cover picture includes: L. to R., back row: Miss Acland, Miss Campion, Mrs. McLeod, Miss DeMarsh. Front row: Miss Gauthier, Mrs. Lacey, Miss Hermanson, Mrs. Patterson.

The course included lectures, demonstrations, discussions and practice drills. For the drills, each representative was issued a coverall suit, long woollen socks, high rubber boots, tin helmet and rubber gloves. This costume produced some rather bizarre effects as the civil defence novices plodded out to the practice areas. Apparently, the extreme gravity of civil defence has precluded any consideration of *haute couture.*

CIVIL DEFENCE PLANNING IN ACTION

The first points to be discussed were the principles of organizing a city for civil defence. On a large floor map of Ottawa, the essentials of organization were displayed. Small colored models represented control centres, fire disposal areas, warden posts, medical assembly points, first aid stations, welfare centres and other key stations. By the ingenious use of a magnesium flare and luminous painted models, it was possible to show the expected result of an atomic explosion on a given area and the procedure for the effective operation of the civil defence plan.

Instructors explained the effects of an atomic explosion and the hazards of radiation. An outside "radiac exercise" afforded the women an opportunity to handle some of the instruments and to measure the radiation from small amounts of radioactive cobalt.

The principles of combustion and the hazards of fire were discussed and the operation of various types of fire extinguishers was demonstrated. Then, garbed in coveralls, rubber boots and helmets, the representatives went out

Basic fire fighting

for practice in fire fighting. This involved the use of extinguishers to put out real fires.

Some of these fires were set in corrugated metal huts and a type of fire cracker was used to simulate the explosion of incendiary bombs. Needless to say, the leaping blaze and the unexpected explosions caused much excitement. Although there was considerable fun and laughter, all the women were made conscious of the underlying danger of fire and the necessity for prompt and efficient action to control it.

Usefulness of Women Shown

Most of the women were extremely interested in the health and welfare services required for civil defence organization including: nursing care, donor bleeding, feeding, clothing, shelter and information. These are the areas where women can make their greatest contribution.

Miss Evelyn Pepper, nursing consultant to the Federal Civil Defence Health Planning Group, and chairman of the C.N.A. Public Relations Committee, gave a most stimulating talk on the essential health services and the role of women in providing them. Miss Pepper stressed the need for emergency planning to meet natural disasters in our communities and demonstrated how civil defence planning could cope effectively with fires, floods, epidemics and other catastrophes.

In speaking of newer developments in civil defence planning, the important role of the smaller communities in assisting larger centres to combat the cumulative effects of a disaster was emphasized. Home nursing training was recommended for all women and two new portable teaching units were demonstrated as a means of extending home nursing training to women in smaller communities or areas where teaching facilities are not available at present.

The over-all planning and organization of health services was well illustrated by the use of slides. Statistical data regarding the preparedness of nurses for disaster nursing included the following:

> 1,300 graduate nurses have taken the 3-day instructors' course; 28,000 graduate nurses have received 12 hours of training; student nurses in five provinces are receiving instruction in disaster nursing; nursing assistants receive 8 hours of instruction in their course; trainees in home nursing receive 4 lectures of an hour each.

The welfare services, including food, clothing and shelter were outlined by other speakers. This information was highlighted by an experiment in emergency feeding. The principles underlying the building of various kinds of outdoor fireplaces were described. Then the teams vied with each other to scrounge bricks, mud and turf, to build their stoves and prepare coffee for the morning break.

Women to the Rescue

The real test of feminine strength came with rescue work. First there was instruction and practise in tying various knots, to show how "casualties" may be securely lashed to the stretchers, and safely raised or lowered with stout rope. Instruction covered casualty handling, debris clearance, raising and lowering ladders. Then the women were grouped in teams and given practice in rescuing victims.

Two-point suspension

One team was assigned a casualty who presumably was trapped in a cellar with the staircase destroyed, leaving only a very narrow aperture through which the rescue party could crawl. It was decided that some should go to the roof and lower the necessary equipment through the elevator shaft to the rescue party below. After the casualty was securely lashed to the stretcher, he was hauled up the elevator shaft to the roof and then lowered over the edge to the waiting stretcher party below. The brave volunteer casualty was finally delivered safely to the first aid group and the women rescuers thankfully descended the ladder to the ground.

One morning was devoted to instruction on the tactical operation of a Control Centre. There was practise in sending and receiving wardens' reports, plotting the information, and dispatching the required aid.

The Bomb and a Mid-Air Suspension

All this was but a prelude to the exciting events planned for the last day. Lots were drawn for assignments, such as radiation monitoring, rescue work, fire fighting and emergency feeding.

Following a briefing on the general plan, the "bomb" went off with quite a display of pyrotechnics. The rescuers, rather clumsy in their awkward garb, hurried off to the warden control post.

Briefing the rescue party

Our rescue party was told to report to a warden in a designated street, where an apartment house and some smaller dwellings were "demolished." Four people were known to be "trapped" in the debris. The location of a rescue truck was indicated but it was left to the team to locate and rescue the casualties. After clambering over debris, shouting and knocking to locate trapped victims, efforts were localized for their release. It was necessary to determine the order of priority for the rescue operations. A man trapped on the second floor, supposedly suffering severe internal injuries, was selected first. He was wrapped in blankets and securely lashed to the stretcher. The party then hoisted him out of the window for a "ladder slide." To our chagrin, one rope caught under the ladder leaving the patient half out of the window. It was necessary to accept help from the instructor in raising the stretcher high enough to free the rope. After this, however, the stretcher slid safely down the ladder to the waiting party below.

Next, some of the debris, wood, bricks, and furniture were cleared from the area around the second patient. It was ascertained that he was in no inmediate danger and not too severely injured. He was assured that the rescue party would return as soon as possible.

The third casualty was a man in a cellar, presumably with a fractured arm and thigh. A path was cleared to the cellar window and the party crawled in. After applying the necessary splints, he was lifted to the stretcher and securely lashed to it. It was necessary to stand the stretcher in an upright position in order to turn it in the very small space and place the patient's head at the window. Then the stretcher was raised and the casualty was shoved through the window.

In the meantime, others had finished clearing the debris and had rescued those casualties who were more able to help themselves. Still another rescue team had been assisting casualties trapped upstairs. These were rescued by lowering them from the roof.

In the meantime, the fire fighting parties had been busy with the many fires, while the radiation monitoring team had detected and measured the extent of the radiation.

Food for the Weary

Most important of all to that tired group of women, the emergency feed-

The hungry ones

ing units had been busy building their stoves and lighting fires. They prepared an excellent meal of beans, wieners, canned salmon, bread and butter, canned pears and coffee. This was quickly disposed of by all the women and the press representatives who were on hand.

A Job for all Women

It would seem logical that civil defence planners should not exclude women from basic rescue work in devastated areas. The women themselves should be made conscious of the many less arduous but extremely important tasks that they can perform in their own communities.

Devastation and disaster are not limited to atomic attacks. Last October's Hurricane Hazel, striking swiftly and unexpectedly, and accompanied by torrential rains, caused heartbreaking havoc in southern Ontario. If every community was fully civil defence conscious and well organized with trained personnel, much loss of life in any disaster could be avoided and immediate aid made available to reduce the amount of suffering and hardship.

As stated in the beginning, nurses know what will be expected of them. There is, unfortunately, little understanding of the many ways in which *all* women could and should be prepared and trained for disaster. This course was a good beginning. With certain changes and re-emphases it should be possible for hundreds, thousands, of women to become completely familiar with all of the vital routines.

Let us not wait for disaster to strike! Let us all be active in urging our local authorities to prepare an efficient civil defence organization to guard our communities!

In the Good Old Days

(*The Canadian Nurse* — February 1915)

"Courses in hospital administration are now given in several of the larger hospitals in Canada. Nurses who undertake to superintend a hospital, however small, should graduate in hospital administration as well as from their training school."

* * *

"In hospital circles we very frequently hear of shortages of staff and overworked nurses. Alas, it is only too true! In the last decade there has been a trend towards supplying more help but there is still room for improvement.

"The hospital I superintend accommodates 90 to 100 patients. We have a graduate nurse on each floor, (three in all), a graduate in the office and one for night superintendent."

* * *

"No better school of diet can be found than an intelligently managed hospital. Even though the patient stays only a week or ten days, he should have learned something that will benefit him later, for cleanliness and proper meals must be insisted upon."

* * *

"Many novels of recent publication are giving the general public the impression that the graduate nurse is little worthy of the status of her calling. As a heroine of fiction — to judge by such novels as 'The White Linen Nurse,' 'A House in Bloomsbury Square,' or 'Nurse Isabel with her Nine-button Boots' — the trained nurse on private duty appears a very flippant, if rather attractive, young woman, boasting many mercenary and vain ambitions, carefully disguising a really kind heart, some small proportion of common sense and aptitude for making the best of her slender educational advantages."

X-Raying all Patients

E. L. Ross, M.D.

THE DISCOVERY of previously unknown tuberculosis of the lungs by means of x-ray surveys of apparently healthy people is now recognized as an essential part of an adequate antituberculosis program. Indeed, it is the very spearhead of a preventive program, for it finds tuberculosis at an earlier stage than any other known method of case-finding as applied to the community. Through surveys and clinics there have been 1,500,000 free chest x-ray examinations in Manitoba in the past seven years. During a year over 100,000 people, about 15 per cent of our population, are admitted annually to general hospitals for all sorts of conditions other than certain known infections, such as tuberculosis. The setting up of a tuberculosis case-finding service for this large, easily accessible group offers an excellent opportunity of extending the discovery of new cases and making the spearhead into a broad advance along the whole line.

The x-raying of general hospital admissions gives an opportunity of discovering chest disease in many individuals and groups who may not be reached by general or industrial x-ray surveys — for example, the mother, the maid, the self-employed tradesman or craftsman, the aged and, most of all, the busy housewife. Women of childbearing age have a definitely higher-than-average morbidity from tuberculosis, yet it is difficult to assemble them either for mass x-ray or for special individual examination. If we can catch them, incidentally as it were, when they come into general hospital for other necessary care, we will have gained a point in the perfection of the coverage of our preventive campaign.

Tuberculosis is often considered a disease of youth. Contrary to this opinion mortality figures show that the highest death rate from tuberculosis occurs in the 70 and over age group. Preventive efforts have resulted in a marked decrease in deaths among the younger persons but there has been no corresponding decline among the aged. The significance of this, from the point of view of prevention, is that elderly people with tuberculosis are spreaders of infection and may go along unsuspected of the disease because they themselves have become tolerant of the toxins and show no symptoms or signs or, if they do, these are likely to be masked by the infirmities of age or chronic senile conditions. Elderly people make up a relatively large proportion of general hospital admissions. Whenever one of these with unrecognized open tuberculosis is admitted to a ward he becomes a menace to fellow patients and doubly deadly to hospital personnel. This hazard can only be avoided by routine chest films.

Nurses entering training are x-rayed on admission to make sure they are free from tuberculosis. We can keep them free only if we are aware of every case of open or potentially open tuberculosis that is admitted to the wards of their hospitals. We can become aware only by x-raying every admission the moment they are admitted.

Thus far I have noted two compelling reasons for taking x-rays of all general hospital patients and personnel — first, to serve the community as a case-finding centre; secondly, to protect the hospital's employees from spread of tuberculosis infection brought in by patients whose open tuberculosis is unsuspected and, therefore, undiscovered. There are other reasons. Early and accurate diagnosis of chest conditions is always an aid to the physician and an asset to the patient. Even when no tuberculosis or other chest condition is found it narrows the field of differential diagnosis and is a factor in the elimination of loose and inaccurate diagnoses. Significant non-tuberculous chest conditions will be found — abnormal hearts, malignancies, mediastinal tumors, atypical pneumonias, cysts, diaphragmatic hernias, and enlarged mediastinal glands. All of these may have been unsuspected and are worthy of elimination by this

Dr. Ross is medical director, Sanatorium Board of Manitoba, Winnipeg.

simple measure. Even in themselves they are good and sufficient reason for pausing on the way through the admission room to trip a switch and make a permanent x-ray record.

The program to x-ray general hospital admissions was initiated in Manitoba in 1949. Starting in the larger metropolitan hospitals in Greater Winnipeg, the program has gradually expanded to include 31 hospitals, 24 of these in rural Manitoba. These hospitals are responsible for 80 per cent of all patients admitted. Our objective is that all hospitals in the province with x-ray equipment should have routine chest films of their admissions and plans are now underway to include those not already participating.

In 1951, the 31 hospitals admitted 83,877 patients and 55,688 or 66.3 per cent had admission chest films. Besides this, 5,086 out-patients and 3,407 hospital staff x-rays were taken, making a total of 64,181 for this particular case-finding project. It will be noted that 66 per cent of the admissions were x-rayed. A constant effort is maintained to x-ray as close as possible to 100 per cent. Many hospitals get over 80 per cent and one as high as 94 per cent. It has to be kept in mind that all cannot be included — e.g., the newborn, the critically ill or injured, readmissions after a short interval. Some patients are in and out in a day or so and are missed. The question is often raised as to whether or not readmissions should be x-rayed. If there is only a few weeks' interval it should not be necessary but, by and large, we think everyone should be included thus eliminating inquiries as to previous admission films.

In hospitals having less than 1,000 admissions annually standard-sized chest films are taken for which the hospital is reimbursed by the Sanatorium Board. If the annual admissions exceed 1,000 it is more economical to instal equipment to take miniature films.

Findings

The value of this program in discovering unsuspected tuberculosis is evident. Many found are spreaders or potential spreaders of infection. Appropriate measures for treatment or follow-up of the patient and contacts can be instituted. Hospital staff are protected from unknown sources of infection and many significant non-tuberculous chest conditions are discovered.

1. Out of 55,688 patients, 71 had apparently active tuberculosis. This is 1:784 compared with 1:3,321 found by community surveys the same year.

2. One in 141 had apparently inactive tuberculosis or disease of questionable activity.

3. Including suspects with the above, 1:79 had either past, present or suspected tuberculosis.

4. The value of this project is more far-reaching than the discovery of tuberculosis; 2,403 or 1:23 had some non-tuberculous pulmonary abnormality.

5. 3,022 or 1:18 had x-ray evidence of some cardiovascular abnormality.

6. The number of out-patients x-rayed has been doubled. Among the 5,086 in this group 13 or 1:391 had apparently active tuberculosis. This project provides a valuable extension to free and convenient chest x-ray service in the province and supplements our travelling clinics and surveys. Survey suspects are referred to the nearest hospital for a large x-ray film.

7. Tuberculosis developing in general hospital nurses in the past was a problem of great concern. Twenty-three years ago, of the female patients on treatment in Ninette one out of every nine was a nurse or nurse-in-training. This hazard does not exist now because of the generally lessened opportunity for infection, freedom from exposure to unknown sources of infection in hospital due to the routine chest filming of patients, and also by the protection afforded by B.C.G. vaccination. Of the 3,407 hospital staff (mostly nurses) x-rayed no case of active tuberculosis was discovered.

Special Comments

Obviously the value of this program is in direct proportion to the percentage of the admissions x-rayed. Although it is appreciated that many factors, mostly concerning staff shortages, may detract from the ideal objective, I do urge that all admissions have a chest film — if not immediately on admission then as soon as possible.

Out-patients referred by doctors may be x-rayed in the same manner as the admissions. This program should not encroach upon the ordinary revenue of the x-ray department but will provide a chest x-ray service for anyone in the community whom the doctor considers needs a chest film but who may not be able to pay for it. Mass x-ray surveys discover suspects requiring further study using a standard-sized film. If our travelling clinics cannot promptly make this possible we refer them to the local hospital.

We advise that all staff members in contact with patients be x-rayed twice a year and the others annually.

It is important that hospital authorities be advised of any chest disease discovered as soon as possible, not only in the interest of the patient but also for the protection of the staff. Films should be read and promptly reported upon. In sending in the films the x-ray card should not be stapled to the film. It only has to be removed when read, which takes extra time. This is important when several thousand a year are sent in. Just send the card loosely with the films.

This whole project has been financed by federal grants and subjected to close scrutiny by the Treasury Departments of both the federal and provincial governments. The Sanatorium Board is responsible for accurate and specified accounting procedures, which is greatly facilitated by the hospital's cooperation.

This program is an important contribution to the protection and promotion of health among the people of the community and also provides a valuable service to the hospitals and attending physicians. The whole project has provided an invaluable liaison with general hospitals and has created an added consciousness about tuberculosis and other thoracic diseases among doctors and hospital staff who are now more than ever before partners in a winning battle against tuberculosis.

At Home in a Residence

PHYLLIS BLACK

WITH THE OPENING of the Margaret Bartlet Nurses' Residence at the Essex County Sanatorium, a long-felt need was met and for some a dream realized. My predecessors had for years advocated a residence to relieve the appalling condition of nurses being housed in various parts of the hospital buildings where privacy was unknown. An increasing demand for student affiliation in sanatoria led the building committee to believe that a teaching unit was essential. The new residence provides both modern teaching facilities for students and an attractive and comfortable home for nurses.

While our new home cannot be compared with many large modern residences with great teaching areas, long corridors and elevators, still we can claim the word *home* — for it truly is that. The presence of women on all committees connected with the building project and especially the one concerned with the furnishings, has resulted in a very practical and tastefully decorated residence.

The site of the residence is ideal. It is apart from the hospital — not too far to cause a problem in winter weather but far enough to permit recreation without disturbing the patients and to achieve the psychological effect of being away from the hospital. The outside appearance is most pleasing — colonial in design with shuttered windows and surrounded by trees. Attractive landscaping around a residence on sanatorium grounds is more easily accomplished than at a general hospital because, down the years, pleasant surroundings have been considered an essential part of the treatment of tuberculosis.

Our residence is provided with ample reception rooms and ideal fa-

Miss Black is director of Nursing at the Essex Community Sanatorium, Windsor, Ont.

cilities for entertaining. As one enters the front door there is a full-length mirror on the left and a small reception room on the right. This room is used for private visiting and is decorated in soft shades of brown and aqua. The main lounge is a long, bright room with a real fireplace at one end and a 21-inch T.V. at the other. An original painting by a Canadian artist hangs over the mantel on each side of which are booklined shelves. This room is decorated in a modern manner with mushroom walls and rug. Brass fire irons, growing plants, and other bric-a-brac add a homey and "lived in" air to the lounge.

Adjoining the lounge is a spacious kitchen — not a kitchenette but a real kitchen that any bride would envy. The walls are yellow with dainty curtains in green and yellow shades at the window. There is a full-sized refrigerator, modern electric range, ample counter space and many cupboards. Along one wall is a dinette set where nurses eat breakfast on days off just as they would at home. Electric kettle, pop-up toaster, plenty of utensils, and dainty dishes enable even the most amateur cook to readily prepare a hearty meal. This kitchen proves a boon to entertaining.

In the director's suite, the modern decor of the other living rooms gives way to walnut period furniture, flowered draperies, and rose colored rugs. A large cupboard in the bathroom and a walk-in clothes closet off the bedroom provide extra space. The assistant's suite, though smaller, is equally attractive. The 25 individual bedrooms (all single) are furnished in maple with matching draperies and spreads. Each is provided with a basin and a mirrored medicine chest, over which is a good light. A bed lamp and floor lamp are also part of the furnishings of each room.

The bathroom facilities are more than ample with one toilet to every four persons, one tub and one shower to every five. All bathrooms are tiled in interesting shades — primrose, turquoise, sea blue, petal pink. Bathroom windows are curtained, taking away that bare, institutional look.

Adequate laundry space is provided in the basement with four double laundry tubs and three ironing boards. The basement is bright, high-ceilinged and well ventilated. It has mastic tile flooring throughout and the walls are pale peach. There is also a large luggage room.

A tastefully decorated recreation room with kitchenette adjoining and a rest room with day beds and comfortable chairs is provided for the use of nurses who live out.

The classroom, lounge, and all corridors have sound proofing.

Since this is a small sanatorium it was felt that a large classroom could serve as an auditorium as well. On one side we have the instructor's desk and blackboard with tablet arm-chairs facing them. When the occasion arises, the classroom becomes an auditorium by the addition of stacking chairs. Since the beginning of our student affiliation the classroom has taken on an air of occupancy with bulletin boards kept up to date by the students. The library, too, has a well-used appearance. We have included bookshelves and racks for periodicals, a table and chairs so that the students have a place for quiet study.

It is the hope of those of us engaged in tuberculosis work that we may interest today's students in this particular branch of nursing. If education is "atmosphere as well as instruction" we feel sure that students from general hospitals will receive great benefit from a month or two spent in this and similar surroundings.

Wheat is the basic cereal of Europe, the Americas, Australia, and a large part of Asia. Rice is the dominant cereal food of Southeast Asia (including China, India, and Polynesia), with a population of more than a billion. All countries use other available grains too, but to a minor extent compared with wheat and rice. For example, in Canada we use for human food about seven pounds of oats, and less than one pound each of barley and corn per person a year, compared with 200 pounds of wheat.

The Prostatic Problem

MANNING L. MADOR, M.D.

THE PROBLEM of prostatic disease is the aspect of urology that presents the greatest challenge to both doctors and nurses. Our population is steadily comprising a larger and larger percentage of older people. This has posed a problem to the medical world. What special and unique attitudes must be developed in the treatment and care of this older age group?

Advancing years exact a penalty from the human body. Every system undergoes changes as the result of long years of wear and tear. The arteries become harder and lose their resilience. They do not deliver the required amounts of life-giving blood to the important structures of the body, such as, the heart and brain. The brain becomes a bit starved for oxygen and food, and begins to undergo certain degenerative changes. Digestion is no longer an unconscious routine process. In man, the prostate gland begins to enlarge, probably because of changing endocrine influences.

There is much that we do not understand about the prostate. Its true functions are largely unknown. Situated at the outlet of the bladder, it surrounds the post-urethra. It is this critical location that makes the enlarging prostate such a vital problem. As the gland enlarges it progressively narrows the outlet from the bladder. The urine can no longer be easily expelled. The bladder, which is only a specialized muscle, must work harder to perform its function. For a time this is enough and the patient may not realize that there is anything wrong. But, if the condition is not corrected, the bladder gradually loses its ability to compensate and begins to dilate. It cannot get rid of all the urine so a certain amount remains in the bladder at all times. This is termed *residual urine.*

Dr. Mador is consultant in urology, St. Joseph's Hospital, Sudbury, Ont., and lecturer in urology to the St. Elizabeth School of Nursing and the Marymount School of Nursing, Sudbury.

This residual urine inevitably becomes infected and cystitis results. If the condition is allowed to proceed unchecked, the bladder opening will become more and more closed off until complete retention results.

The bladder is not the only portion of the urinary tract that is affected. The increasing back pressure is transmitted up the ureters until they also are dilated and incompetent. The kidney is the ultimate victim, finding it harder and harder to do its work in the face of this inexorable back pressure. In time, as the kidneys begin to fail, the patient is rapidly approaching a crisis. Uremia may result. If nothing is done the patient, of course, will die.

As a result of the renal damage, a certain amount of toxemia is present. This exerts an effect on every system in the body. The blood shows an anemia that is often very difficult to treat. The heart shows some myocardial changes. The brain undergoes certain toxic changes. The gastrointestinal tract shows congestive changes. All these things result from the urinary obstruction. It therefore becomes most important to relieve this obstruction before all these changes become irreversible. Relieving this obstruction means removal of the obstructing prostate.

In its early days prostatic surgery was very deadly. There were many reasons for this. Fifty years ago an operation was performed only in the most desperate cases. Infection and hemorrhage were ever-present complications and the management of cardiovascular problems, diabetes, etc., was not too effective. How has this type of surgery become safer?

1. Better pre-operative care. This includes attention to electrolyte balance, blood studies, nutrition, etc.
2. Early ambulation.
3. The free use of whole blood.
4. The use of antibiotics.
5. Improved nursing care. In most hospitals today, female nurses will look after these patients with a minimum of Victorian modesty. There is no need to

rely on the inexpert orderly to look after the important details of post-operative care.

Let us look at one of these patients on admission to hospital — an older man with marked prostatic symptoms. Because he has severe frequency, he has probably stopped taking much fluid. He will appear dehydrated. The nocturia has disturbed his rest to such an extent that he is literally worn out. His hemoglobin is probably low. The gastrointestinal tract has suffered so loss of appetite and constipation are evident. Due to some loss of control, he will have a certain aroma of ammonia about him. Above all, he is probably quite fearful, not knowing definitely what the trouble is, nor how much help he can get. If he has talked to his friends or relatives, he will probably be scared silly over the prospect of the "horrible" things that are going to be done to him. In no other condition has such a mass of rumor and weird tales arisen.

This, then, is the type of case that presents itself — perhaps a bit exaggerated — but essentially this is the problem. Our first and most important task is to reassure the patient. This is not just a glib statement, "You will be all right!" Every effort must be made, especially by the nurse, to allay the patient's fears. He should be put to bed — rest is important for this ailing, weary man! The retention of urine is relieved, usually by an in-dwelling catheter. Once this is done, he is encouraged to drink, and drink, and drink. There is no use in putting a great heavy pitcher of water beside the bed and telling him to drink. The nurse must see that he does it. The glass has to be filled for him if he is too feeble or disinterested to do it himself. One to two glasses each hour is usually enough. However, intravenous therapy may be necessary. A sedative is usually given. This provides rest and allays fear. Phenobarbital or chloral hydrate are suitable. If there is infection, antibiotics are used. Under this treatment the patient usually improves rapidly.

As soon as he is fit pyelography is done. This tells a great deal about the condition of the kidneys. Cystoscopy follows and gives details of what type of obstruction is present and what the inside of the bladder looks like.

There are various ways of dealing with the enlarged prostate:

Transurethral resection: This method has undergone continuous change over the past fifteen years. An attempt is made to completely remove the adenoma. If the gland is not too large, if the patient is a very poor risk, or where there is a small fibrous prostate, transurethral resection is the method of choice. It is truly amazing how these terribly poor risks tolerate such major interference. Spinal anesthesia is used if at all possible.

Suprapubic: This may be done in one or two stages. It is rare, today, to require preliminary suprapubic drainage. The first stage operation is usually done. The bladder is sometimes tightly closed, but usually a suprapubic catheter will be left in for one or two days.

Retropubic: In this method the bladder itself is not actually opened. After removal of the adenoma, the prostatic capsule is tightly closed. This usually means very little suprapubic drainage and a smoother convalescence. This method is preferred by many surgeons as the routine open operation.

What about post-operative care of these cases? A continuous, irrigating Foley catheter is used in transurethral and retropubic cases. A continuous drip of normal saline is passed into the inflow and the outflow is connected to a drainage bottle. The rate of drip depends on the amout of bleeding. This is usually discontinued in 24 hours and the catheter allowed to drain into a bottle. The catheter is removed four to seven days after operation. Due to irritation from the operation, and the presence of an inflated balloon, there may be considerable bladder spasm. The patient expresses an intense desire to void in spite of the fact that the catheter is draining well. Opium and belladonna suppositories are useful here. Pantopon is a very good narcotic — usually gr. 1/6 q.4.h. If possible, patients get out of bed on the second day. Again, fluids must be forced. Intake and output must be charted. Enemas are routinely given on the third day unless otherwise ordered. After removal of the catheter voiding must be carefully checked. This is usually done by the doctor.

It is very unusual to see the mentally deranged patient of 25 years ago on the urology ward. Because of careful attention to fluid balance and drainage, the cerebral symptoms that were so common in earlier days do not occur.

The over-all mortality rate is low. One per cent is considered usual. This is truly remarkable considering the age and general condition of patients who need this type of surgery. Prostatectomy by some method is possible in almost 100 per cent of all cases. There is practically no contraindication to surgery. Hemiplegics, paraplegics, heart failure cases, mental cases — all these can usually be handled by the transurethral route.

I realize that I have skimmed over some of the highlights of this problem. Each day brings new experiences and new methods for dealing with prostatic disease. I would like to stress again that the nurse can and does play a very important part in treatment. It is her encouragement of the patient, her attention to the many details of postoperative care, and her recognition of the danger signals of hemorrhage that spell the difference between success and failure in prostatic surgery.

I will conclude with a few words about cancer of the prostate. About 30 per cent of men who have symptoms of prostatic trouble are eventually found to have carcinoma in the gland. The symptoms are often the same as in benign disease. Sometimes a bad sciatica, severa anemia, backache, or blood in the urine are the chief symptoms. Very few of these cases are found early enough for even radical surgery to be of any avail. However the use of stilbestrol or some other female hormone has enabled us to offer these patients a great deal of comfort and added years of life. If the cancer produces blockage of the urine, transurethral resection will relieve the trouble.

Have You a Ward Manual?

MARJORIE E. HEWITT, B.A.Sc.

PERHAPS not so long ago, you began work in a new situation with unbounded enthusiasm, but ended the day, lost in a fog of confusion and fatigue. Your head was swimming with unsure ideas of "The procedure to follow in the event of . . ." or "No requisition is required for . . ." Perhaps you were told that everyone found it difficult at first. That is scant comfort when a ward manual could have lessened that confusion for you, and at the same time been an asset, not only to the new graduate, but also to students and graduates in everyday situations.

What is a ward manual? A ward manual or hospital routine book supplies information regarding accepted hospital policies, directions for ward and interdepartmental administration, examples of completed administrative aids and forms. In contrast to the regulation "procedure book" which consists of detailed performance instructions, the ward manual serves to facilitate relationships between hospital departments.

At the request of the superintendent of nursing, a ward manual committee of seven was formed. This committee consisted of the assistant superintendent of nursing, the educational director, three teaching supervisors, and two clinical instructors. All were nurses who were thoroughly familiar with our hospital routines. I was elected chairman because of previous experience in preparing a ward manual.

At our first meeting, we listed what we thought should be in a ward manual for our hospital and what a graduate, coming on staff, would want to know. Our thoughts ran something like this: "How is blood ordered? How do you get crutches for a patient? Who takes the patient down to physiotherapy?" and so on. This chaos was unscrambled and we formed a temporary index.

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A topic was assigned to each member to investigate and record.

For all members a copy of each report was typed, and at subsequent meetings reports were checked and edited for validity, definiteness, and expression. If it is to be a guide, the content must be brief but comprehensive. Statements must be specific and accurate. Nothing should be taken for granted or left "to read between the lines."

The next problem was how to organize this material so that it would be of most value. From reference reading we learned that indexing was an art, but, only two methods were suggested:

1. That the book be divided in sections, with each section identified by a colored card.
2. That the book be alphabetically listed, and numerically numbered in pencil.

We preferred to index our pages by alphabet and number as for example:

Accidents	A 1
Autopsy	A 2
Authority to Operate	A 3
Beauty and Barber Service	B 1
Brace Shop	B 2
Blood Transfusions	Refer to L 1
Call System	C 1
Canteens	C 2
Central Supply Room	C 3
Consultation Records	C 4

Each topic was typed on a separate page. By this method revision can be made by removing the page, yet indexing is still in order. Similarly a new topic can be added without interfering with the overall pattern. To make revision simpler a loose-leaf book was chosen. All revisions should be dated.

The manual, as it is being used, is far from perfect but a start has been made. It will serve as a basis for future elaboration. Our aim in preparing the manual was:

1. To establish a certain degree of definiteness about correct procedure.
2. To eliminate the time-worn practice of passing on the greater part of the hospital's policy by word of mouth.
3. To serve as a text of approved practice in this hospital.

Will a ward manual fulfill these functions? The answer will only be yes, if it is used. It must therefore be accessible to all and kept up to date. Supervisors and head nurses must be familiar with its content, so that when inquiries are made, reference can be made immediately to the manual. In orientation programs, new graduates must be given time to study the book. Criticism from all staff members, both constructive and destructive, should be sought. Only by this means will the real value of the ward manual be proved.

May I recommend the following significant points to those who wish to prepare a ward manual for their hospital:

1. Allow plenty of time. This project cannot be done in days. Our manual took approximately six months to complete.
2. Key personnel should be represented on the committee and responsibility for writing should be delegated to them.
3. All material must be checked and edited for definiteness, accuracy, and clarity of expression.
4. The manual must be kept up to date. A standing ward manual committee should be formed.

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To keep frost from forming on windows this winter, rub the inside of the panes with a solution of an ounce of glycerine in a pint of rubbing alcohol.

— C.I.L. *Oval*

Before painting window frames, rub soap all over the panes of glass in the window, then when the painting job is finished, any paint that has spattered the glass can be washed off easily.

— C.I.L. *Oval*

Being on the right track doesn't mean a thing unless you keep moving.

NURSING SERVICE

The Nursing Service Budget

EDITH YOUNG

THE MOST IMPORTANT and effective technique in the efficient operation of any hospital is the preparation of a budget leading to budgetary control.

A separate budget should be made for each department. It is essential that the responsibilities of each department be clearly designated so that there will be no overlapping of responsibility, and therefore, of dual budgeting for one service or area.

In some hospitals the Executive Committee prepares all the department budget estimates and submits them to the department heads for revision and approval. The better method, however, is to have each departmental estimate prepared by the department head, since he is accountable for the performance of his department and is held responsible for accomplishing the results outlined by the budget. While preparing the budget, the department head is likely to pay more attention to the factors related to the expenses of his department and to plan how the budget can be realized. Furthermore, he develops a sense of responsibility for its accomplishment and at the same time gains a knowledge of the problems to be solved.

THE NURSING SERVICE BUDGET

The nursing service budget is a part, then, of the over-all hospital budget. The director of nursing must actually initiate her own budget and recognize it as her goal. She is the only one qualified by complete knowledge of nursing service to do the job adequately. She must be concerned with financial matters if she is going to develop an efficient budget. Since the director of nursing is responsible for the administration of the nursing department, she should be informed with reference both to the cost within her own department and to the financial status of the hospital as a whole. This information can be furnished by the Accounting Department in such form that it can be interpreted and used by the director of nursing even though she has not had any prior technical training in the preparation of a budget. Frequent discussions with the hospital accountant should produce important operating information as well as a better understanding of the entire financial structure of the hospital. Responsibility and authority must go hand in hand since no one can be held responsible for any operating function unless he has been given the necessary authority to control such function.

In a recent survey conducted at San Francisco, it was found that, of the total expenditures by a 400-bed hospital, approximately 30% were under the control of the director of nursing. Further analysis showed 41% of total salaries and wages were expended in nursing care, the school of nursing, sterile supplies, operating and delivery rooms — all areas under the director of nursing.

These statistics reveal the importance of the nursing service budget and its control. The director of nursing should, as has been stated, be cognizant of the financial picture of the hospital as a whole and should discuss this information with those members of her staff who have the responsibility of supervision of personnel and supplies. Costs of linens, bandages, instruments,

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and other supplies should be made known to all personnel who use them so that they will realize the importance of care and economy in their use. Planned visits to the central supply room, with demonstration of equipment and information as to its cost, or price lists sent to the ward twice yearly may have some effect on the personnel assuming responsibility for equipment.

General Principles of Budget Preparation

The budget period should coincide with the accounting period of the hospital and should be prepared on the basis of the hospital's fiscal year. Income and expense items in the budget should follow the same account titles used by the accounting department.

The nursing service budget should be subdivided to facilitate making estimates since, in a hospital conducting a school, two types of nursing activities are carried on — one educational and the other service. For clarification of these activities and to show their service, educational and financial relationship, a statement of the expenses of the two should be prepared as two separate parts of the budget. Furthermore, where such exist, there should be separate subdivisions for the operating room, delivery room, nursery, emergency department, out-patient department, nurses' residence, etc.

Preparation of the Budget

The steps involved are: Briefly recording past experience as a basis for making estimates for the future; anticipating factors that will affect future items of income and expense; making a preliminary draft of the budget and analyzing each item to determine whether it is established on the most efficient and economical basis possible; and setting down the final estimates to be used as a guide for operations during the coming year. Figures of previous years' expenditures can be obtained from the business office of the hospital. If the director of nursing is not familiar with accounting terms, each expense account should carry a clear and logical definition, understandable to her. In addition to statistics on income and expenses of her department, she will need statistics showing the percentage of bed occupancy by months, the number of employees, divided into their various classifications, and the number of hours of volunteer work contributed by various organizations. Since the major part of the nursing service budget centres around salaries, the first step is for the director of nursing to analyze the nursing service needs of each ward and unit.

There is no set pattern or device for determining the numbers and types of personnel needed by the hospital as a whole. Each hospital has variations and, therefore, individual needs. The following are factors that must be considered.

1. Type of patient — medical, surgical, maternity, pediatrics, communicable disease, chronically ill, tuberculosis, etc.
2. Size of unit.
3. Plan of the ward — open ward, small units, or private rooms.
4. Physical facilities — number of sinks, type of screens, location of utilities and of equipment, size of offices, charting rooms, etc.
5. Provision of central supply room, recovery room, time-saving equipment, such as flash autoclaves, electro-vox, telautograph systems, pneumatic tubes, etc.
6. The availability of graduate and auxiliary workers and their ratio.
7. The number of work hours per week and flexibility regarding them.
8. The amount and quality of supervision available and provided.
9. Nursing school — type and extent of nursing service by students. This in turn is dependent upon the type of educational program provided.
10. Method of assignment of nursing personnel — is it the functional or patient method of assignment? The latter, while assuring better nursing care, requires more personnel. Is the team plan of nursing used?
11. Standards of nursing care — frequency of giving baths, changing beds, turning patients, giving back care, attention given to comfort and safety measures.
12. Method of performing nursing procedures — whether simple or complex.

12a. Time required for hospital routines. Is there a complex system of record keeping and reporting? Are all

routine procedures or baths and back rubs charted; all medications required to be on the nurses' notes, or is a work sheet and checking system used?

12b. Whether the reports required by the administration are simple or complex.

13. Whether accounting procedures, such as, census, giving out cheques, etc., are the responsibility of the nursing or the accounting department.

14. The method of appointment of medical staff — closed or open — the size, activities, kind and frequency of treatments, orders, etc.

15. Whether there is an affiliation with a medical school — inexperienced medical students need more equipment and supplies, cause more confusion and interruptions.

16. Rules regarding visitors.

It is also necessary to anticipate other factors that may affect costs during the coming year. Any of the following may affect the budget planning:

Is there anything that may affect the hospital bed capacity?

What is the current trend in bed occupancy? This is one matter which, at the present time, needs little consideration as, in general, beds are reoccupied almost immediately.

What is the local population trend? This is applicable only in certain centres and under certain conditions, such as the opening of a new industry, etc.

Are there any possible methods of reducing expenses without reducing the quality of service?

In order to determine whether work is being done by the most efficient method, a job analysis may be essential. It may lead to a re-arrangement of duties with resultant reductions in salary or wage expense. A simple method is to have all personnel on a typical unit record their activities for a period of two weeks. While this is not a scientific analysis it is a guide as to whether or not certain tasks currently performed by a graduate nurse could be assigned to a nursing assistant without affecting the quality of nursing service.

An example of this change-over in our operating room may be of interest. Previously, graduate or student nurses were responsible for selecting and preparing instruments for various operations. Now, the nurse's responsibility for instruments ends when the operation is completed. Auxiliary assistants trained "on the job" are responsible for cleaning, sorting, and packing all linen, instruments, needles, etc.

Time and motion studies are, of course, of much greater value in determining whether nursing service is being conducted as efficiently as possible, but this method is expensive. Simple techniques may have to be used because of the cost.

It is good administrative practice for the director to determine the number of personnel required for nursing service not only on the basis of hours per patient per day (using A.H.A. and N.L.N.E. "Essentials for good nursing service"), but also to study nursing personnel as noted above. It is of value to have a sketch made of each unit and indicate the personnel required for nursing service right on the sketch. By doing this, each unit will have a standard of the minimum number of personnel (listed according to status) required to give safe nursing care. This is a double check in determining the nursing service requirements and is an effective visual method of interpreting nursing service needs to the medical superintendent and the Finance Committee.

The Salary Scale

The salary scale should be considered well in advance of budget time. A classification chart that defines the duties of personnel in each category should be prepared. In certain situations, consideration should be given to the establishment of different grades. For example, the head nurse may have a unit of 25 beds, 35 beds or even 50 beds. She may or may not be required to assume teaching responsibilities in addition to administration of the unit. Within this group, therefore, different grades should be established, for example:

Grade I — smaller unit without teaching responsibilities.

Grade II — smaller unit with teaching responsibilities.

Grade III — larger unit without teaching responsibilities.

Grade IV — larger unit with teaching responsibilities.

Salary levels should be established for each grade.

The point system of salary rating may be used to good advantage but, again, to do this efficiently is an expensive matter.

The director of nursing usually is required to give considerable guidance in salary scales in her department. These scales should be reviewed annually. Several devices may be considered as tools to emphasize the needs for good personnel policies as related to salary:

Percentage turnover of personnel — this can be secured from the personnel department in the larger institution and from the nursing office records in smaller units.

Salaries recommended by the Registered Nurses' Association of the province in its personnel policies.

Salaries in hospitals of comparable size under the same type of government.

Salaries in hospitals in the same area.

Proximity to higher educational institutions, cultural advantages of community.

Relationship in cents per hour of salary of public health nurses, etc. in the same community.

Number of hours on duty of hospital nurses versus public health, and also requirements of shift duty.

Every hospital should have a minimum and maximum quotation of salaries. The statement should be *gross* whether or not perquisites are included. If nurses are required to live in residence, (and I do not believe this should be a requirement even for the director of nursing), then consideration should be given to actual charges for maintenance. For those who voluntarily live out of residence, such consideration is necessary.

The director of nursing must consider not only annual increases for tenure, but any contemplated changes — in union agreements, if such exist, or in working conditions. For example, the introduction of a pension plan would cause a significant increase in the cost of salaries. Vacation, sick leave — based on the average amount of illness per day the previous year — and expected turnover should also be weighted.

Next, ascertain what changes are contemplated, such as opening new facilities for patients or changes in other departments which affect the nursing service required — programs of education or research, changes in nursing school curriculum which may affect the amount of nursing service given.

Prepare the program which the new budget is to cover in terms of nursing hours to be given to patients, the distribution of the hours among the various groups of personnel, the ratio of supervisors and head nurses to patients, and the provision for the administration of the nursing department. While a certain amount of uncertainty is inevitable, it will be found, after a little study, that it is possible to establish the cost of payroll fairly accurately.

Equipment

Considerable information can be gained as to the equipment needed by sending a questionnaire to each member of the administrative, teaching, supervisory, and head nurse staff. It is important to list individual names and ask each person to return the form whether anything has been listed on this questionnaire or not. An example of the type of questionnaire which might be sent out follows:

The budget for next year is to be estimated before the end of this year. Kindly indicate on the back of this sheet the requirements of your department.

(a) Structural changes desired.

(b) Equipment needed, such as desks, cabinets, carts, or equipment of similar type.

(c) Replacements of equipment of an extensive nature.

(d) Miscellaneous items.

Please return this form not later than (a specific date).

Have the chiefs of staff or various services make any specific recommendations relating to equipment and supplies, and ask the nurses in charge of the units to record these also on the same form.

Preliminary Draft

The size of the hospital does not, in itself, determine the question as to whether the nursing department is supplied with regulation forms by the

hospital administrator on which to make out its requests, or whether the allowances for salaries, supplies, and such other items over which budgetary authority has been delegated to the nursing department shall be listed on a simple sheet of paper. The following example may prove helpful:

Nursing Administration

Salaries — Director of nursing, assistants, office secretaries, clerks, etc.

Supplies and Expenses — Printing, stationery, postage, office supplies, or any other supplies requisitioned from stock, books, periodicals for library in school programs, etc.

Equipment — Ordered by special purchase requisition, such as, typewriters, filing cabinets, etc.

Purchased Repairs — Repairs for which payment is made to an outside agency, such as typewriter repairs.

Clinical and Other Divisions

Salary and wages — Supervisors, head nurses, staff nurses, nursing assistants, nursing aides, other auxiliary workers and clerks.

Supplies — All supplies and equipment used on the nursing units issued from stock, for example — enamel or glassware, dressings, adhesive, thermometers, soap, ink, pencils, etc.

Equipment — Additional or for replacement; not carried in stock and ordered by purchase requisition, for example — oxygen tent, suction machines, expensive instruments, etc.

Having reviewed the information received from nurses in charge of units, and having conferred with them, the next step is to study the budget appropriation and the actual expenditures for the current year in conjunction with statistical data as to the numbers and distribution of patients, nursing hours per patients by services, operations, and other pertinent information.

To develop a budget, the necessary forms and procedures must, of course, be prepared by the administration in order to have the same techniques used throughout all departments and to finally assemble valid summarizations. The basic set of forms must be given to each department head to start the planning. This set should consist of one form for the development of salary expense.

In our nursing service department, the personnel on duty on the first day of each month are checked with the estimated number for each department monthly. Thus it is rather simple to develop the department work sheet for the budget along these lines shown below:

For payroll control every group, or if desired every employee, should be assigned an appropriate number. This control number should be used on all payroll and budget records.

This list can easily be prepared from the personnel book. If listing each employee in so much detail is not desired, this form should then carry the number of employees in each job classification — that is, head nurse, assistant head nurse, general staff nurse, nursing assistant, etc. — with the average salary paid, average annual increase and average proposed new annual salary, and should be totalled for the entire group. For key personnel, or groups that are stable, the detailing of each position is a very effective educational medium for the administrator to know his organization.

SALARY SCHEDULE
Department Work Sheet

1	2	3	4	5
Approp. Number	Status	Date of Appt. to hospital	Date of Appt. to present position	Present Monthly Salary
6	7	8	9	10
Monthly Salary Requested	Date to be Effective	Reason for Requested Increase	Total Salary Requested	Blank

In dealing with groups that inherently have very high turnover, and in very large hospitals, it may be impossible to work with this amount of detail and the grouping technique may thus be necessary.

Supplies

If this responsibility is assigned to the director of nursing, all groups of supplies should be listed on a Supply Sheet in the same manner as carried in the accounting system so that issuances can be properly charged and control can be accomplished by providing each department head with an identical monthly breakdown of actual expenditures throughout the year. The information regarding supplies should be completed by the business office on the forms, prior to sending them to the department head for completion.

ful because of a time lag between budget preparation and actual requisitioning procedure, during which time personnel changes, or failure to remember, necessitates referral to records to see who participated in requesting items of equipment.

The final summary sheet of the Accounting Department will also contain accounts for the use of the business office for all general expenses which may be allocated in the accounting procedures to all departments, for example — the cost of heating, light, general maintenance, etc.

Completed budget estimates can now be made for each income and direct expense item under the control of the director of nursing for the coming year. To develop cooperation and understanding between the department head and the administration and to obtain

Supply Schedule
Department Work Sheet

1	2	3	4	5
Supply Acct. Title	Last Year's Actual Expense	Current Year's Expense, month	Current Year's Estimated Expense, Total	Total Requested for Budget, Year

The procedure of completing this detail is a most enlightening educational experience for the department head and does more than anything else in developing cooperation in administrative matters. To be at all accurate, the department head must review department procedures and usage of supplies and must avail himself of market knowledge to predict next year's needs by "item classification." Obviously an "other expense or miscellaneous" account must be used as an allowance for unforeseen contingencies.

If all other items are carefully considered, this catch-all amount should be minimal.

Columns 7 and 8 are extremely helpful

preliminary approval for major changes or major items of equipment, the department budget should be reviewed by these persons prior to final completion and submission by the department head. Totalling of columns should not be done by department heads but should be left to the business office because of the difficulty in making changes in case of error. Department heads should be encouraged to complete the totals in their work copy, which they retain, in order to acquaint themselves with the total cost of departmental operation.

After such careful analysis and consideration the budget will be established on a factual basis and will

Equipment Schedule
Department Work Sheet

1	2	3	4	5	6	7	8
Line No.	Item Description	No. of Units	Cost per Unit	Reason for Request	Total Amount Requested	Requested By	Quoted By

represent a well organized plan for future operations.

At this point I would like to stress the impossibility of going through the budget and eliminating a flat percentage rate down the line. This is true because extensive consideration of all details should have been taken into account by the director of nursing in preparing this budget. After such consideration it should be virtually impossible to reduce the amounts established without reducing the quality of nursing service. If the total estimated expenditures are greater than the hospital can hope to defray, adjustment can theoretically be made only by eliminating or curtailing some special service or services.

Advantages

There are several clear-cut advantages to operating on a well prepared nursing service budget:

1. *Maximum cost control:* Cost accounting is a worthwhile managerial tool but is, however, typically a post-mortem activity which does not have much therapeutic value for the period covered, simply because that period is always past. Budgetary control is concerned with the future and provides an opportunity for management to set an expense pattern that will help provide the desired end result. In some hospitals where budgetary control is not used control of expenses, particularly those for supplies such as linen, have been attempted through the "shortage method." This is economy in reverse as it means more trips to laundry daily, greater frustration, and a greater turnover of nursing personnel. Advance planning that goes into budget preparation is the best way to generate cost-consciousness on the part of each member of the staff.

2. *Orderly guide to operation:* The budget provides a well organized plan for the most economical use of personnel and supplies. It is based upon actual facts and consideration of the needs of the department rather than on last year's estimates or hastily prepared calculations. It helps to place executive financial planning upon a scientific basis.

3. *Periodic examination of performance:* Efficiency of the department is examined periodically and current performance is checked with established policies giving management a means of effective analysis.

Reports should be prepared for each department by the accounting office on a monthly basis. This report should show the actual amount spent for each account classification in the current year and in the preceding year. Variation in budgeted estimates and actual expenses are thus revealed. It must be noted that variation between budgetary and actual expense in any one month is not necessarily a poor budgeting performance, as factors such as the time of student vacations, etc., vary the amount of graduate nurse personnel required in any one month. Monthly or quarterly figures should be used as a guide in judging progress.

An investigation of variations must be made and their cause should be analyzed to facilitate proper expense control. When the important variations have been isolated the director of nursing should take the corrective action necessary, or if this is impossible, state so in writing to the administration. A budget supplements the director of nursing's experience and skill. It is not a substitute for them. It reveals any divergency early, so that she may quickly and effectively control expenditures before the divergency becomes of any consequence. Since the director of nursing must plan her operating program in terms of financial results, as well as in care of the patient, the budget enables her to criticize her own planning. At the same time, it provides a defence against unjustified attacks. If, for example, comparison of budgeted and actual expense items reveals a substantial increase in salaries of general staff nurses for inpatient care, the director of nursing must make an analysis of the individual items entering into that expense for the month to determine what has caused the increase. Investigation of the reasons for the increased expenditure may reveal that it was due to factors not taken into consideration when the budget was prepared, for example: a fewer number of student nurses than was anticipated or a change in teaching schedule allowing fewer hours of nursing service by students.

4. *Advance information:* The budget gives management an opportunity to discover adverse developments before they

occur, thus pointing up the need for consideration of expansion of the budget. It also provides essential information for negotiating with representatives of unions, government bodies or organized plans for hospital care.

5. *Financial evaluation of nursing:* The governing board of the hospital as well as the administration and the director of nursing are enabled properly to evaluate the nursing service position in the financial standing of the hospital.

6. *Review of hospital policies:* Drawing up the budget requires the review of policies and accomplishments during the past year and the restatement of policies and plan of operation for the ensuing fiscal year. It points out in what respects the estimates were poor and in which they were good. These facts, together with the reasons for the differences, provide valuable guides in preparing the budget for the next year.

Budgets in Small Hospitals

The size of the hospital has little bearing upon the necessity for planning. Budgeting is just as necessary for small as for large institutions, and the procedure is fundamentally the same in both cases. It is not, as is sometimes suggested by the administrator of a small institution, too costly or unsuited to its limited needs. Lack of a budget is much more costly.

Only if the director of nursing is fully aware of the values of budgeting in the administration of her department will she take part in this picture. Her responsibility for the nursing service and for maintenance of hospital policies will be facilitated by a budget developed by her which can be used as a standard for performance of her department and which provides for more effective control of its operation.

For the New Mother

Betty Gray

Editor's Note: When she was a senior student at Port Arthur General Hospital, Miss Gray attended a joint conference of the maternity department where methods for improving the quality of nursing care for obstetrical patients were being discussed. One of the problems that was considered was how to establish a better rapport with the large number of New Canadians who had little or no understanding of our language and customs. On her own initiative following the conference, Miss Gray prepared the material contained in this article. With the warm approval and commendation of the obstetricians, it has been translated into Finnish, German, Italian, Polish and Ukrainian. All patients receive a copy in their own language on admission.

This seems an excellent yet simple way to bridge the gap of language difficulty in a busy maternity department. The material is presented here in the hope that other hospitals may find it helpful in solving a similar problem.

When first admitted to our floor, you will be asked a number of questions. We have to know your name, doctor, the number of times you have been pregnant. If this is to be your first child, then you usually will have a longer labor than if it is your second or third. The time when your pains started and the length between pains is also noted on admission. At first your pains are likely to be irregular, occurring off and on throughout the day. As you enter into true labor they become more regular with about ten minutes between. As your labor progresses, this time becomes shorter and shorter — from six minutes to five to three and eventually every minute to a minute-and-a-half. Then the baby is almost ready to be born. These pains are actually contractions of the womb, which contains the baby. With each contraction your baby is gradually pushed through the opening of the womb, down the birth canal and is thus born.

The baby is encased in a bag of water in your body. We ask you if the water has broken or not, when you are admitted. This bag of water may break

before labor starts, after labor has begun, or sometimes it does not break. In that case the doctor will break it when the baby is ready to be born. This water protects your baby from any bumping or jarring while it is growing in the womb and also moistens the birth canal so that the baby can move a little easier along it.

There is a collection of mucus plugging the opening of the womb. This comes away as the opening becomes bigger and bigger. A show of blood will occur as this happens so we ask you the approximate time this occurrence took place if it was before your admission to the hospital. If it did not occur before, the nurses will watch for it during your labor. This is a normal process and indicates that the womb is opening. You need not be alarmed by this show of blood, as it is a sign that your labor is progressing naturally.

When you are in bed, we examine your abdomen to discover if the baby is lying in normal position. We then listen to the baby's heartbeats with an instrument placed against your abdomen. The purpose of this is to make sure the baby is acting normally and is in no distress. A check is made to see that your blood pressure, temperature, pulse and respirations are within normal range. If they show any dangerous signs, the nurse will carry out the necessary precautions. A specimen of urine is also tested to make sure it too is normal. We then shave the hair from your perineum and upper thighs to help insure a clean area for the baby to be born through. The nurse will then do a rectal examination. In this way she is able to feel how much the womb is opening and how far the baby's head has come down. You are then given a warm enema to clean out the lower bowel and to stimulate contractions of the womb. After this has been completed you are asked to sign your clothes' list so that your clothes may be put away in a locker.

Normal Labor

Normal labor consists of three stages:

The *first stage of labor* lasts from the time your pains begin until the time when the opening of the womb is as wide as it is able to stretch. During this time the nurse will watch you. The time between your pains becomes shorter and shorter, the pains themselves become stronger and sharper as labor progresses. It is important that you relax and that you are not afraid. Fear causes a tightness of your muscles that will only increase your pain and not aid in any way in the delivery of your baby. The nurse will tell you to take deep breaths during your pains and how to relax between them. You may be given a hypodermic injection or a pill to help relieve your discomfort.

A check is made periodically on your blood pressure and the baby's heartbeats to make sure that all is well. The nurse will make several rectal examinations so that she will know exactly how much the womb is opening and when it has opened completely. When you start to feel a pushing sensation with your pains, as if you were going to have a bowel movement, it is an indication that the second stage of labor is approaching and you are immediately moved from the labor room into the delivery room.

The *second stage of labor* lasts from the time the opening of the womb is complete until the baby is actually born. As soon as you are on the delivery table, the nurse gives you a few whiffs of an anesthetic. A mask is put over your mouth and nose and all you have to do is take deep breaths when the nurse tells you to. Straps are fastened around your wrists, not to tie you down but to keep your hands away from the sterile sheets the nurse will be putting over you. Your abdomen, perineum and thighs are then washed with a solution of dettol and painted with an antiseptic solution called zephiran. This is to help remove germs that are present. The nurse, who has scrubbed her hands and put on a sterile gown and gloves, places the sterile sheets over you and then helps the doctor with his gown and gloves. The doctor delivers the baby. Sometimes the baby's head is a little too big to come through the normal opening. If this is the case it is necessary for the doctor to make a small cut to enlarge the opening. After the baby is born he will put in a few stitches to close the cut he has made.

The *third stage of labor* begins as soon as the baby is born and ends with the delivery of the afterbirth. After the baby is born the womb does not contract again for five or ten minutes. With its next contraction the afterbirth comes away. The nurse massages the womb to make sure it stays firm so that the amount of bleeding will not be excessive. You may be given a few whiffs of anesthetic throughout the delivery of the baby and the afterbirth. The sheets are removed and you are made comfortable.

When you waken the nurse will take you back to your room to rest and to see the new baby you have brought into the world.

The Meaning of Illness

Avis Pumphrey

A thorough medical examination of every person would probably reveal a number of abnormalities — defective vision, heart murmur, tendency towards diabetes. These are "normal" to the extent that we are used to them and have, in general, adjusted to them. Workers in industrial plants fall into this same group and only a small minority are incapacitated or chronically ill. These industrial workers, like you and me, may therefore be considered as a healthy group of people.

What meaning does illness have to normally healthy people? Why do patients react so differently?

We tend to take for granted that illness is invariably a calamity. As we study the reactions of our patients we realize, however, that illness has an individual meaning to each one, tied up with home and work situations and sometimes even reaching back into childhood and the patterns of behavior that were established at that time.

You and I, working constantly with sick people, are apt to have our sensibilities blunted. We overlook the fact that Mr. A.'s sudden illness or accident is a traumatic event to him and we may, at times, look on him as just another injured hand or attack of appendicitis. As members of the medical team of doctor, nurse and social worker, we need to be aware of the real meaning of this illness to the patient. The patient who reacts violently to having an injection may have a shadowy memory of some old wives' tale of death from poisoning. He may recall daily, or vividly, the suffering of some loved one whose medical treatment included injections. There may be dozens of other reasons, conscious or unconscious. In the same way, we must realize that a general anesthetic is usually very frightening to a patient since it is "first cousin" to death itself. It means giving oneself over to another person completely, putting one's life in the hands of the doctor and nurse. We must not, therefore, belittle this experience but must build up the patient's trust in us as competent, reliable persons who understand his problems and appreciate his anxieties. We need to caution ourselves against a tendency to project our own feelings onto our patients. Our reactions, too, are individual.

Medical science today treats the patient as a whole — not just the particular portion of him that is ill. The medical team is interested not only in making the patient well but in keeping him well. In order to do this we need to study why the patient became ill or had an accident. In this way we may be able to help him avoid further attacks or accidents.

To give a simple example, let us presume that Mr. B. slips on the stairs and breaks his leg. It is not enough to set his leg and plan treatment. We

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Miss Pumphrey, who is director of the Department of Medical Social Work, The Montreal General Hospital, gave this paper at a conference of industrial nurses held at Queen's University, Kingston, Ont., last summer.

should also inquire into the reasons for his fall. There may, of course, be an obvious cause such as greasy substance on the steps, or worn heels on the worker's shoes. We should not overlook causes of an emotional nature. A quiet discussion with the patient may disclose that he is concerned over home matters and was thinking about them instead of his work. Perhaps his wife is pregnant and they consider themselves unable to support another child. Perhaps he has just been reprimanded by his boss and is angry or even alarmed at possible consequences.

Often we may help to drain off emotional tension just by being willing listeners. The "fifty cent word" for this technique is catharsis, which means allowing the patient to "blow off steam." As professional people we are safe recipients of confidences because we will not repeat them to unauthorized people. With the patient's consent, however, we may help him to obtain certain help from the community — V.O.N. visits for his sick wife, casework service from a community agency. Maybe our help will consist of nothing more than listening and expressing understanding of his particular anxieties and problems.

Many industrial concerns have regular chest x-rays for diagnosis of tuberculosis. Where a diagnosis is made, the patient is in immediate need of help from the nurse. In addition to the more obvious duties of x-raying others in the family and instructing the patient in proper techniques, there is a need to understand what this illness means to that person. The diagnosis is almost certain to come as a shock. The patient should, therefore, be encouraged to talk, to cry, to express — in whatever way comes easiest to him or her — the deep emotion being experienced. It is sometimes embarrassing to us to witness such outbursts and, if we do not watch ourselves, we may be inclined to dam up the outburst and try to calm the patient. This is most unwise.

A psychiatrist working with tuberculosis patients states that all patients, at the point of diagnosis, are mentally ill. This phase may last for only a few minutes or it may be more protracted. Through catharsis, we allow him — even encourage him — to express himself, however incoherent he may seem to be. Gradually, as the emotional storm blows over, the patient becomes calmer and is able to face his changed situation. Only then is it safe to help him to discover the meaning of illness to him. It may mean financial stress, involving referral to a social agency. It is possible that the diagnosis may actually come as a relief and that admission to a sanitarium will be a welcome rest from too great strain in his life situation. He may be able to use his enforced leisure to work towards training for a more suitable occupation. Rehabilitation starts at the point of diagnosis and should not be overlooked.

The onset of illness can have many meanings, and these are seldom evident on the surface. Let us turn for a moment to an actual example and study it.

Mr. R. was admitted to hospital following a heart attack while on the job. Physical examination revealed no marked abnormalities of the heart and the doctor suspected that the symptoms were caused by an acute anxiety state. Casual discussion with the patient revealed little that was helpful. Mr. R. had been 20 years with the same company where he was considered to be a valued employee. He was married and had five healthy children. A social history was requested by the doctor.

Do you recall Mr. Milquetoast in the cartoons? Our Mr. R. was his double — a gentle, quiet, hard-working man, overly conscientious, easily alarmed. His wife was a big buxom woman who dominated him and made constant demands for more money. The children needed shoes; Mary wanted piano lessons; Johnny required skates. At the plant, Mr. R. was dominated by his boss who constantly refused to give him higher wages. In desperation, Mr. R. worked harder and harder but never could catch up with his bills. Finally he collapsed. When he was admitted to hospital, three men were required to do his work at the plant.

It was a big plant, and our doctor got in touch with the medical department there. The directors were consulted and Mr. R.'s work record was reviewed. He was transferred to another department, under a more understanding boss,

and the long-deferred increase went through. The social worker had a talk with Mrs. R. who, alarmed at her husband's illness, was easily persuaded to treat him with more consideration. After a week in hospital, Mr. R. returned home and to work and has not been readmitted.

What did this illness mean to Mr. R.? At the onset of symptoms, he had literally "lost heart." The doctors tell us that the heart muscle is "the great actor," reacting rapidly to emotion. We know from personal experience how our hearts will thump when we are alarmed. Under the severe and continual strain of mounting anxiety both at home and at work, Mr. R.'s heart reacted violently and precipitated a crisis. His illness, in actual fact, was the best thing that could have happened to him. As a result, the strain of years was relieved and he was enabled to have renewed hope and satisfaction in his home and work.

Illness, therefore, means different things to different people. In our society we accept the concept that sick people should not be expected to work. Social assistance is granted on the basis of inability to work due to illness. The healthy person, on the contrary, is expected to work. The fact that work is scarce, that men are being laid off, is not accepted as a reason for giving relief. The fact that a workman has low intelligence and poor physique is not a valid reason for granting relief. Illness therefore can, under certain circumstances, have great meaning and value.

Let us consider Mr. S., a man of frail physique and dull intelligence, who is married and has two healthy children of 5 and 7 years. He works as a laborer and maintains his family in a small inexpensive flat. Times are bad and getting worse. Men are being laid off every day. Mr. S. sees the "writing on the wall" and becomes very anxious about his family. If he loses his job he will not be eligible for assistance. His job is not covered by unemployment assistance. What is he going to do?

Maybe Mr. S. was so concerned about keeping his job that he became over anxious and fumbled his tools. Whatever the cause, he had an accident and severely injured his left wrist. He was admitted to hospital and his family was granted social assistance while Workmen's Compensation was under consideration. The wrist did not heal and, in due course, Mr. S. was referred to the tuberculosis unit, where a diagnosis of tuberculosis of the bone was made. Workmen's Compensation was refused on the basis that the bone condition was present prior to the accident. The case dragged on, and Mr. S. became steadily worse, wracked with anxiety over his family and his inability to support them. Finally, shortly before his death, Workmen's Compensation was granted, providing a measure of security for the wife and children.

In this instance, illness had great meaning. Here was an ineffectual man, without sufficient strength in either mind or body to support his wife and children. When threatened by loss of his job, he welcomed the accident that made him eligible for social assistance. When he died, he was grateful that his accident had made possible a permanent pension to care for those dependent on him.

No two cases are alike, and illness often has ramifications far beyond what one might anticipate. Even the tragedy of terminal illness sometimes has unexpected results.

Mr. and Mrs. X., with their two small boys, came from Europe to start life in the new world. Mr. X was a willing worker and he quickly obtained work in a large industry. He had to be trained so that his wages were quite low. The family lived in two rooms. Mrs. X was cheerful and plucky but she soon began to feel quite unwell. Finally she came to clinic, where cancer of the cervix was diagnosed and immediate admission recommended. Mr. X. managed as best he could, arranging for the children to stay with a neighbor while he was at work.

It became evident that Mrs. X. would not live much longer and plans would have to be made for the care of the children. In order that Mrs. X. might participate, the doctor gave her her diagnosis. She had anticipated it and accepted it bravely. She expressed a wish to spend her last few months at home if that were possible.

The men at the plant heard this story and decided to help. Mr. X. located a four-roomed shack and, with the assis-

tance of his fellow workers in the evenings, he winterized it. One man donated a furnace and another installed it. Furniture arrived from all sorts of unexpected donors. All of a sudden, Mr. X. found he had made a host of new friends and was no longer a stranger in a foreign country. He was one of a community. A service club undertook to pay the wages of a housekeeper and Mrs. X. was triumphantly escorted home. Christmas that year was a wonderful experience and she was even able to help with decorating the tree. By the time she died in the spring, she was able to see her husband once more completely self-supporting, making good wages and surrounded by kind friends. Illness in this family, although full of tragedy, had yet brought great happiness and had established this little family.

Industrial nurses are called upon to give service in all types of cases. It is not enough just to give first aid treatment. As a professional person, it is highly recommended that she look beyond the obvious and recognize that the workman — male or female — may well be using the excuse of a small ailment in order to ask for help in a larger problem. I suggest that she ask herself: "Why has this woman developed a headache?" By all means give her an aspirin, if that seems indicated, but also take time and give her the opportunity to discuss the reason for her headache. Is she sleeping well? Does she have eye strain? What does she do after working hours? What are her responsibilities?

If she indicates a serious social problem, then ask if she would like to be referred to an appropriate social agency. Become familiar, by personal visits and discussions with the personnel, with the main social agencies in the community. If possible, arrange with some social worker to use her as a clearing house. Some industrial nurses in Montreal use me in this way. When they uncover some social problem among their patients, they call me and we discuss it. Because I know the community well, I am able to advise the nurse where her patient should be referred. Social workers are always willing to be used in this way. The patient thus avoids a "run-around" and goes directly to the proper resource that can give the necessary assistance. Realize also that "assistance" does not necessarily mean financial help. The workman may need casework — professional help with personal worries. The social workers are there to give this help.

In conclusion, may I stress again that every person reacts individually to illness, and that illness or accident has special meaning for each one. A workman, for instance, who becomes deaf may either be deeply depressed because he is closed off from the noisy world about him or, alternatively he may welcome the quiet. He may get satisfaction from no longer hearing his nagging wife's complaints! He may qualify for specialized work in an especially noisy plant with heavy machinery. He may, on the other hand, be desperately lonely.

As professional people, we should recognize the meaning of illness to each one. We must strive always to be sensitive to the needs of every patient, treating them with respect and understanding. If our manner is casual and indifferent, the patient is at once aware of it and will react with hostility. The nurse in industry has an important role to play and can be one of the most valuable resources in helping the workman to get well and stay well, both physically and emotionally.

Almost all paved roads tend to become slippery when wet — thus creating an additional accident hazard to already harassed motorists. This situation has been the subject of intensive research by engineers at Carborundum Co., Niagara Falls, N.Y., who have come forward with what appears to be a sound solution.

Now on the market is a product known as Highway Safety Grain, a special aluminum oxide abrasive to be spread on smooth roads. A recent test indicated that the stopping distance of cars travelling at 30 m.p.h. on a wet asphalt highway was reduced by more than 30% when the oxide was applied.

As a contribution to the reduction of auto accidents, this aluminum oxide abrasive may become very important. — *Aluminum News*

NURSING EDUCATION

Psychiatry—An Integral Part of Nursing

SISTER M. BENEDICTA

THE AIM OF THIS PAPER is to focus a new light on psychiatry so that its rays may penetrate nursing instead of being confined to an isolated experience of an affiliation. It seems timely when the new Curriculum and Information for Schools of Nursing "stresses better correlation of subject matter and avoidance of regimentation into compartments.[1]"

Our attention has been drawn to the report of a study made by Miss Matheney at New York University on "How does the Psychiatric Nursing Affiliation Fail?" This study indicated that most of the students did not learn normal behavior through a twelve-week affiliation "since psychiatry in general is concerned with personality defects and weaknesses, less with personality strengths.[2]"

Facts and figures compiled by the National Association of Mental Health reveal the alarming increase of mental illness and other personality disturbances. "The trend, (as in other branches of medicine) is towards prevention, early recognition and treatment. This means an extensive educational program.[3]"

In *The Canadian Nurse,* October 1953, with reference to Miss Doucett's article on Psychiatric Nursing Affiliation, we read the following comments[4]:

> . . . the amazing ignorance of the present day development in the care of patients in mental hospitals . . .
>
> . . . that there are not enough opportunities provided for every student nurse in Canada to participate in a twelve-week affiliation course.

Is there not in all of this a challenge to nursing education?

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In our school, we are attempting to integrate the psychic aspects of nursing throughout the curriculum. I shall now present the outlines for the courses, whose central objective and/or contributory objectives pertain to psychiatry in some of its ramifications. Many schools will have already included much of this subject matter, but possibly with a different emphasis.

Religion:

To show that religion is the foundation of personal and social sanity, a strong anchor in life's emotional crises, and that it gives purpose for human suffering, mental as well as physical.

To point out that many competent psychiatrists recognize the therapeutic value of religion in cases of mental disturbances and confusion.

To explain that religious people may become mentally ill, but their conflict may not be of a moral or religious nature, that they may become mentally unbalanced on the subject of religion because of false interpretation of religious precepts or of an erroneous conscience.

To distinguish between the conscious guilt of formal sin and the guilty feelings which stem from an unconscious source.

Psychology:

To explain the psychosomatic nature of man, and the dignity of the human person, his origin and destiny, in order to clarify the students' philosophy of life, and to develop in them respect for the intrinsic dignity and inviolability of their patients.

To give an understanding of the physio-psychological acts of sensation and emotion.

To introduce terms relating to disturbances of sensation, e.g., hallucinations, delusions, disorientation.

To describe abnormal emotional states,

e.g., hysteria, obsession, anxiety.

To instruct on the human specific endowments of intellect and will.

To acquaint the students with the philosophy of Freudian psychoanalysts who deny the existence of God, religion, sin, free will, moral law, and who see all mental disturbances as directly related to sex.

Personality Development:

To develop an appreciation of the interdependence of the spiritual, physical, emotional and intellectual factors in the development of an integrated personality.

To familiarize the students with factors which contribute to the shaping of one's personality, and the importance of exercising the will.

To illustrate the role of emotions in the total personality.

To consider the role of mental mechanisms in meeting the ordinary demands of living and their use in abnormal adjustments to reality.

To discuss the characteristics of a mature personality so as to give the students increased insight into their own personality strengths and weaknesses, and acceptance of others.

To acquaint them with the Freudian parlance on the development of personality.

To have the students complete personality studies in order to compare subjective and objective judgments.

Mental Hygiene:

To develop in the students an understanding of the principles of mental hygiene so that they may be motivated to apply them to their own personal lives and integrate them into nursing.

To reiterate the importance of religion and a correct philosophy of life.

To relate factors that influence mental health and which can contribute to mental illness.

To discuss the importance of realistic attitudes towards the problems of daily life, the need of reliance on God, the habit of daily prayer and practice of virtues.

To point out the dangers of wrong attitudes and how they can foster psychopathic personalities.

To familiarize the students with the developments of mental health programs.

Sociology:

To stress the importance of family life on the mental health of the nation.

To acquaint the students with behavior problems and difficulties in parent-child relationships arising out of family disorganization.

To discuss the psychiatric elements of such social problems as chronic alcoholism, drug addiction, juvenile delinquency.

Professional Adjustments:

To include the history of psychiatric nursing in the study of the development of nursing.

To emphasize the role of the nurse in the field of preventive psychiatry and her responsibilities as a member of the team.

Guidance:

To remember that each student is an individual person with a unique background of experience which affects her attitudes towards learning, developing maturity, and adjusting to group living, as well as to the demands of a profession.

To accept, in student nurses, the usual pattern of behavior seen in the adolescent who does not reach emotional maturity suddenly but needs assistance in the application of the principles of good mental hygiene.

To be aware of their basic personality needs, of love, security, approval and understanding, since much of their satisfaction must come from their work.

To utilize the personality study as a tool for guidance.

General Ethics:

To apply the principles of the moral law, conscience, and moral responsibility, to discuss impairment of the freedom of the will as in conditions of anxiety, scrupulosity, compulsions, and other psycho-pathological obstacles.

Medical Ethics:

To consider the morality of narcotherapy, depth therapy, psychosurgery, and psychoanalytic technique.

Psychological Aspects of Nursing:

To discuss nurse-patient relationships through their understanding of personality development and the dynamics of individual adjustment.

To assist them to develop skill in interpersonal relations in the clinical area through the application of Christian social principles.

To familiarize the students with the dynamics of interaction, which can more or less color the patient's reaction to any given situation.

To acquaint the students with the importance of communicating to all patients a feeling of security, acceptance, and confidence, in order to gain cooperation from the patient and create a good therapeutic environment.

To remind the students that grace works through nature and a sick body makes spiritual needs more difficult to attain.

To introduce basic concepts of psychosomatic medicine, as a foundation for developing of correct attitudes towards patients whose illness is predominantly psychosomatic or psychogenic in origin.

Clinical experience:

With the foundation laid for an understanding of what total nursing care implies, provision must be made to develop in the students continued appreciation and awareness of the dignity of the patient in his totality — spiritual and mental, as well as physical — in order to be prepared to meet his total needs. The new curriculum is sufficiently broad in its requirements so that we can keep our teaching patient-centred, rather than disease-centred.

In the discussion of health problems, health teaching, and prevention, include the psychic aspects as well as the physical. This affords opportunities to emphasize the importance of nursing attitudes in order to establish good rapport with the patient.

Health and Social Needs:

To include in field trips to community agencies, visits to a home for the aged; children's shelter; mental health clinic; rehabilitation centre; in order to give the students a better understanding of environmental factors affecting personality and mental health.

To utilize some of the techniques of group dynamics, e.g., role-playing, to enable the students to know something of how it feels to be dependent on others, to be the client at an interview, the counsellor and carry on purposeful conversation, or a good listener.

To discuss the mental health problems of chronic alcoholism as an escape mechanism from insecurity and frustration.

To discuss the nurse's responsibility in recognizing the patient's growing dependence on a drug, and her attitude towards the drug addict so that she may be of some therapeutic value to him.

Medical-surgical Nursing:

To discuss the effect on behavior of abnormalities of the neuromuscular and endocrine systems.

To consider the psychosomatic aspects and psychogenic factors in gastritis, peptic ulcer, colitis, asthma, dermatitis, accident proneness.

To increase their awareness of the psychological effect on the patient who learns he has cancer or serious heart condition.

To familiarize them with emotional disturbances the basis for which may be fear or anxiety due to loss of position, dread of an anesthetic, blindness, deafness, loss of organs.

To recognize the need the patient may have to consider his illness entirely organic, as a face-saving escape from an intolerable situation.

Obstetrical Nursing:

To familiarize the students with the psychological factors of pregnancy and the dangers of unhealthy attitudes, e.g., rejection.

To include in a course on marriage and family relationships a discussion of psychological implications that can give rise to tensions and conflicts.

To clarify the student's own attitudes towards motherhood and family life, enabling them to carry on purposeful conversation with anxious and discouraged mothers.

Pediatric Nursing:

To reiterate the importance of family organization to provide the basic needs for the child.

To study normal behavior in the different age groups and to assist the students to recognize the abnormal.

To help them to understand the emotional problems of children, factors influencing normal personality development, psychological trauma.

Psychiatric Nursing Affiliation:

Since one of our objectives in offering this affiliation is to provide the students with a learning experience in dynamic psychiatric nursing, preparation for this opportunity will contribute towards achieving our aim and will assist the students in adjusting to the new environment.

To assign reading on history and development of psychiatric nursing and mental hygiene and to acquaint the students with some psychiatric terminology

which aids in dispelling many fears of the unknown.

To utilize the psychiatric attitude scale.

To screen a film, e.g., "Breakdown," so as to familiarize them with some of the activities in a mental hospital.

To review moral indications of behavior problems.

To advise them of the dangers of becoming emotionally involved with patients, especially psychopaths.

Following affiliation, a written evaluation of the course by each student is valuable information for the home school.

We have now dealt with the major subjects of the nursing curriculum, but cooperative and coordinated effort of the graduate staff is vital to the implementation of an integrated program. It requires wholesome attitudes and interest, which could be developed to some extent through in-service education. Students will need guidance in the application of principles and techniques of psychiatric nursing as they do in all other branches of nursing.

With psychiatry thus integrated into nursing, less in content and time would be required of the mental hospital offering the affiliation. This in turn would provide opportunities to more of our student nurses in Canada who are now unable to participate in any affiliation.

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Cours de Perfectionnement pour les Infirmières en Exercice

Valérie Detelin

Les écoles d'infirmières d'il y a vingt-cinq ans sortaient à peine des méthodes d'apprentissage. Les cours avaient pour but d'expliquer le pourquoi des choses, mais sans l'appliquer dans la pratique du travail quotidien.

L'enseignement se faisait selon ce que j'appelle "la méthode du tiroir" qu'on ouvrait au début de l'enseignement d'une matière pour le refermer une fois l'examen passé, sans plus y revenir, sans synthèse de ces notions éparses.

Les infirmières d'alors étaient-elles bien formées? Elles donnaient de bons soins aux malades et si elles avaient l'avantage de travailler avec une hospitalière d'expérience, les leçons d'enseignement clinique d'alors étaient aussi précieuses que celles d'aujourd'hui. Mais comment se perfectionnaient les infirmières d'alors?

Elles avaient l'expérience pratique de leur terrain d'action quotidien et Dieu sait si en 11 heures de travail par jour, 6½ jours par semaine, elles pouvaient en acquérir de l'expérience, puis elles avaient les sources de documentations professionnelles. C'est alors que nous avons eu "La collection de la garde-malade" dont les volumes de pathologie, de bactériologie, d'obstétrique, de matière médicale et de neurologie intéressaient encore les étudiantes de nos jours. La première revue professionnelle de langue française "La Veilleuse" prenait naissance. La formation reçue depuis 20, 15, 10 et 5 ans est-elle suffisante pour l'infirmière de 1955? C'est à cette question que j'essayerai de répondre.

L'infirmière travaillant à l'hôpital a

Mlle Detelin est une infirmière ayant des années d'expérience dans l'éducation et le service du nursing.

l'avantage d'être en contact quotidien avec une pathologie, particulièrement instructive. Si elle a le désir de progresser, de s'instruire, elle bénéficie d'une expérience vécue incomparable; si le programme d'éducation du personnel est bien préparé, les échanges entre le personnel des divers services permettront à l'infirmière de faire la liaison nécessaire, de suivre la marche générale du progrès de la médecine, de connaître des techniques révolutionnaires et de coopérer à des recherches prometteuses.

Les heures moins longues de service favorisent peut-être aujourd'hui plus de réflexion, par contre, le changement fréquent de personnel, trois fois par jour, nuit à l'observation et à la synthèse.

Peut-être que l'expérience acquise au chevet des malades par l'infirmière travaillant à l'hôpital peut suffire à celle chargée de donner des soins généraux, mais veut-on la faire passer d'un service de médecine ou de chirurgie générale à un service plus spécialisé que déjà elle se rend compte qu'il lui faut acquérir de nouvelles connaissances pour bien remplir la mission que le médecin attend d'elle, le malade est le même, mais les médicaments sont nouveaux, les examens différents, les appareils plus nombreux et plus compliqués, le régime est devenu une partie importante du traitement. Il lui faut se mettre à l'étude ou elle ne sera pas à la hauteur de sa tâche.

Il en est de même de l'infirmière du service privé, qui bien plus que l'infirmière de l'hôpital doit être constamment sur le qui-vive pour se tenir à la page. Si elle se fie à ses connaissances du passé pour maintenir sa clientèle, elle se verra bientôt mise de côté, elle criera peut-être à l'injustice, mais la véritable injustice aurait été de l'employer auprès des malades.

Il va sans dire qu'il faut une préparation beaucoup plus poussée, supérieure aux infirmières chargées de la direction, de l'administration d'un service de malades, de l'enseignement aux étudiantes ou aux infirmières et de la surveillance.

Que pouvons-nous faire pour nous perfectionner, pour progresser, nous tenir au courant des progrès du Nursing qui marchent de pair avec ceux de la médecine et de la société, subissant les influences de l'économie, de la technique.

Nous répondrons à cette question en deux points. Comment l'infirmière peut se renseigner: 1) par elle-même; 2) avec l'aide des autres.

Par elle-meme

En s'appliquant dans son travail à soigner un malade, un être humain ayant une famille, une occupation etc., et non une maladie, un bobo.

En lisant les revues professionnelles, elles sont écrites pour les infirmières. En reprenant les manuels scolaires. En interrogeant vos compagnes sur leur travail.

Avec l'aide des autres

Rares sont les médecins qui ne vous donneront pas volontiers quelques explications, si elles leur sont demandées au bon moment.

Que votre travail soit du domaine des hôpitaux, du service privé ou de l'hygiène publique, les directrices des écoles, les surveillantes seront également heureuses de vous renseigner soit directement ou lors des conférences du personnel.

Le district No XI l'an dernier a organisé avec l'aide des hôpitaux, des démonstrations d'une très grande valeur, c'était là une véritable occasion de s'instruire, que nous nous devons de signaler. Cette année le programme s'annonce aussi intéressant.

Lors de l'assemblée annuelle, l'A.I.P.Q. essaie aussi de vous renseigner sur un sujet d'actualité.

Enfin, il y a les cours postscolaires, ils sont de deux catégories, 1) ceux qui ont pour but de préparer l'infirmière à donner des soins plus spécialisés aux malades, cours ordinairement donnés dans les hôpitaux, leur durée varie de 4 à 6 mois. 2) ceux qui ont pour but de préparer l'infirmière au poste d'hospitalière ou de surveillante, ils sont donnés par les universités.

Ne faites pas l'erreur de croire qu'en sortant de l'école, vous savez tout et que vous garderez intact votre petit bagage de sciences; pour soigner les malades, soit en service général à l'hôpital, soit en service privé, il faut augmenter constamment ses connaissances.

Le vieux proverbe qui dit "Celui qui

n'avance pas recule" s'applique aux infirmières, à vos connaissances. Posez-vous cette question et répondez sincèrement: "En plus de notre travail, qu'ai-je étudié?" Rien, "Alors que pensez-vous récolter?" — "J'ai fait fructifier mon talent" — alors vous recevrez cent pour un.

In Memoriam

Isobel Florence Grant, a native of Nova Scotia, who graduated from the Massachusetts General Hospital, Boston, died at Montreal on December 25, 1954. Miss Grant had worked in Montreal for the past 30 years.

* * *

Gladys (Tighe) Harris, who graduated from the Hamilton General Hospital in 1921, died there on November 17, 1954 at the age of 56.

* * *

Frances Sarah Hogg, a nursing sister with the R.C.A.F., was killed in an aircraft crash while on a routine flight in 1954.

* * *

Carmel (Mackler) Legary died on December 4, 1954 at Englehart, Ont., following a long illness. Mrs. Legary worked for a time at the Englehart Red Cross Hospital.

* * *

Ellen O'Boyle, a graduate of St. Michael's Hospital, Toronto, died there on September 22, 1954. Miss O'Boyle had engaged in many branches of nursing during her career, including resident nurse at the Ontario Agricultural College, Monteith, assistant instructor later operating room supervisor at St. Michael's and private nursing.

* * *

Elizabeth Regan, a graduate of St. Michael's Hospital, Toronto, died at London, Ont., in December, 1954 after a prolonged illness. Miss Regan served overseas with the C.A.M.C. during World War I. After the war she was associated with St. Joseph's Hospital, Port Arthur, St. Joseph's Hospital, Hamilton and St. Michael's. She retired about 15 years ago.

* * *

Mary Ritchie, a graduate of Soldier's Memorial Hospital, Orillia, Ont., died suddenly on November 27, 1954 in her 45th year. Miss Ritchie had engaged in private nursing for most of her professional life.

* * *

Barbara Maria Simpson, a graduate of Hamilton General Hospital and New York City Women's Hospital, died at Guelph, Ont., on December 3, 1954. Miss Simpson, who was at one time a supervisor at Toronto General Hospital and later was matron of the Barnardo Home for Boys at Peterborough, Ont., retired from active duty in 1929.

* * *

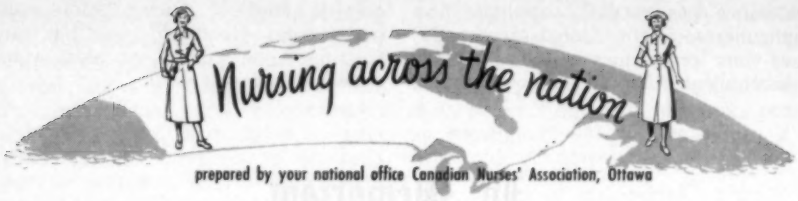
Nellie (Wilkins) Yeates, a graduate of Johns Hopkins Hospital, Baltimore, Md., died at Hamilton, Ont., on November 26, 1954, following a brief illness. Mrs. Yeates served overseas during World War I as a nursing sister at Orpington Military Hospital, England, and later at No. 3 Canadian General Hospital in France.

Gamma Globulin may best be described as a grab-bag of immunity. It is that part of human blood which prevents an individual's catching some infectious diseases twice. It thus carries the antibodies developed to combat a disease during illness. The gamma globulin of a person who has had measles will contain measles antibodies. Consequently, most Canadian adults have antibodies against polio in the gamma globulin of their blood because they have had one or more light cases of the disease without knowing it.

When the blood from a thousand or more different individuals is pooled together, the pool is certain to contain antibodies against polio, measles, infectious hepatitis and probably some other diseases as well.

When the gamma globulin is removed from the pool, the protective antibodies it contains can be loaned to another person who has not developed his own antibodies. This is exactly what happens when a child receives an injection of gamma globulin.

Since borrowed antibodies pass rapidly out of the blood, however, gamma globulin offers only temporary immunity. It protects only for periods up to five weeks. Hence, it is chiefly useful during periods of high incidence, when it either wards off the disease or reduces its severity. — R. L. KING



Variety in Teaching

ALL WHO TEACH HAVE DISCOVERED that while much is accomplished by traditional methods, there are many qualities that can be developed only by the student's active participation in the learning process. How this participation can be made possible through the "case" and "incident" methods of teaching was made clear recently at McMaster University in a special week-long course led by Lucy Beal of Boston University.

Case method teaching, in particular, can help the student to develop her analytical powers, enable her to work a problem through with others and to arrive at a mutually acceptable solution. A case is a good record of some situation that has been faced by people and is a result of the faithful reporting of events that have actually happened.

Students are given a copy of the case for study well in advance of the class. During the class period, they consider it analytically, step by step. From this method they may acquire skill as group members, learn to recognize prejudices and opinions, to evaluate and to arrive at useful generalizations.

The incident method is rather similar, but presents to the class only the precipitating event which implies a challenge to authority. Part of the class will have prepared a complete case report on the incident with all available data. The rest of the class then must attempt to obtain, by questioning the team leader, all the pertinent facts. After evaluating and classifying the data, a decision must be made, both majority and minority decisions being supported by reasons. Perhaps the greatest value of this method is to show that a decision should not be made until all available facts are known.

Some of the instructors who attended the institute at McMaster have since been using the case method in their teaching. Reports of the results of its application in Canadian schools of nursing will be awaited with interest.

What They're Saying About Nursing

The second issue of the CNA's booklet "What They're Saying About Nursing" was distributed recently. It is available in most schools of nursing, in provincial offices and other locations. Additional copies are available to any nurse by writing to National Office.

"What They're Saying About Nursing" is a representative collection of reports on Canadian nursing as they appeared in recent newspapers and periodicals. These press clippings make interesting reading. They also bring to mind some interesting questions: What lies behind these newspaper stories? Where do they originate? Who writes them? How do they get in the paper?

These are questions of interest to all nurses, since what appears in the press has a considerable effect on nursing.

Just as there is planning and organization behind the nursing service that patients see in a hospital, so there is a definite organization behind every story that you see in the newspaper. It is the organization of the newspaper's editorial staff.

Heading up the editorial staff is the publisher — the man who owns the newspaper. Under him may be one, or several, editors responsible for the paper's editorial policy, for the writing of editorials, and for the selection of the news and pictures that appear in the paper. Under the city, or news editor, is a staff of reporters who cover "beats," or certain areas of activity in your town. A newspaper reporter is directly responsible to this editor, both

in the selection and writing of story material.

Stories on nursing may originate in several ways. A large number result from the activities of nurses in local hospitals, public health organizations, industries and homes. If these activities are considered "newsworthy," a reporter is usually assigned to cover the event. Other stories may result from the initiative of the newspaper staff itself. A reporter may suggest to his, or her editor, a particular feature of nursing that might make a good story, or the editor may assign a reporter to cover a feature of interest to the paper's readers. Finally, news stories may develop locally out of press releases from your National Office.

It is important to remember, too, that many radio items and interviews originate with newspaper stories. The local newspaper and radio station are valuable assets in your town. Try to cooperate with their representatives whenever necessary.

Alumnae without an Alma Mater

Three years have elapsed since the first truly independent Canadian school of nursing held its graduation ceremonies. The Metropolitan School of Nursing demonstration project at Windsor, designed to show effectiveness of training nurses in an independent school, is no longer active. But its 87 graduates who were trained in a two-year period, are most certainly active in nursing. The only thing they lack is an Alma Mater.

Although returns are not yet complete from questionnaires sent to graduates of the Metropolitan School, 60 of 87 have replied. At a later date, a full report of the activities of these nurses will be prepared. It is possible now to pick out some interesting highlights. Perhaps the most important is that not one graduate feels she has been handicapped by the shorter period of preparation. In fact, many stated that, because of the greater concentration on the broad principles of nursing, they were better able to fit into all the varied situations in which they found themselves.

Almost 50 per cent report being engaged in bedside nursing, 22 on hospital staffs and five in private nursing. Almost 20 per cent are in public health, evenly distributed between official agencies and the Victorian Order of Nurses. Another 10 per cent have assumed teaching or supervisory duties in schools of nursing. The remainder are nursing in other fields. Twenty-four of the 60 have gone on to take additional preparation at University or in the clinical fields, 12 in public health nursing.

Learning from Other Countries

The Nursing Service Committee of the International Council of Nurses has proposed formulation of "Acceptable Standards of Nursing Service" for particular groups of patients, or specialized areas of nursing service. It has been suggested that different member nurses' associations, such as the CNA, prepare a paper on a specific area of nursing service.

The particular value of this proposal is that the best nursing practices in all countries can be studied by nurses all over the world. In this way, countries with well advanced nursing services can examine each other's methods. Countries with less advanced nursing services may benefit from the accumulated experience of others.

Thirteen countries have now prepared papers on Accepted Standards of Nursing Service. The papers have been circulated to other member countries for their comments, criticism and suggestions. Copies of these evaluations have been sent to the countries from which the papers originated. Each country may then incorporate the suggestions in a revised paper.

To date, your National Office has received 15 papers prepared by 13 different countries. Included have been papers on acceptable standards of Pediatric Nursing Service, Industrial Nursing Service, Mental Nursing Service and Tuberculosis Nursing Service.

The papers have shown considerable variation in scope, detail and treatment, some being more comprehensive than others. Some have been illustrated. All evince much thought, hard work, research and consultation.

Your Association has not yet prepared a paper on Acceptable Standards of Nursing Service. A committee is

now being formed however. Topics suggested for Canada are orthopedic nursing service and poliomyelitis nursing service.

This international assignment emphasizes the close cooperation and understanding that should exist between all branches of nursing service. No group by itself is able to provide total and continuous nursing service for the orthopedic patient. The experience of all nurses is necessary for the best possible preventive, therapeutic and rehabilitative service in both mental and physical aspects. Whether giving bedside care in home or hospital, whether in public health agencies, in occupational health, or in an administrative capacity, each nurse has an important contribution in providing an acceptable standard of nursing service for the orthopedic patient.

Because the CNA now has one committee on nursing service, rather than the three interest groups of the past, it will be better able to complete this important international assignment.

Settling in

Accompanied by the roar of mechanical drills and the hammering of carpenters, your National Office is rapidly settling into its bright new offices in Ottawa. Dealings with provincial, national and international nursing activities are proceeding well from the new quarters.

Thanks to a useful suggestion approved by your Sub-executive Committee, National Office expects to get considerable assistance from married nurses and other volunteers in the Ottawa area. The function of this National Office Auxiliary is to assist the staff with many activities including furnishing the new office, entertainment of CNA guests, possibly the maintenance of archives and other projects. Nurses who have had the happy experience of working with volunteers in nursing, will appreciate the time and effort that will be given generously by these women.

Since arriving in Ottawa, the National Office staff has been augmented by the addition of Mrs. Ethel Armstrong Collins. Mrs. Collins was a familiar person at the Banff Convention and played an important part in the organization of the convention trains. She is the new Convention Coordinator. To tell you that is to forecast another wonderful trip in June 1956 to Winnipeg and to our 28th Biennial Meeting.

As this issue of *The Canadian Nurse* appears, several important meetings are being conducted. In addition to meetings of the Nursing Service and Nursing Education Committees, the first of the two Executive Meetings of the biennium will be held February 17, 18, 19. From then on it will be "full speed ahead for the CNA."

Le Nursing à travers le pays

Variété dans l'enseignement

Les personnes expérimentées dans l'enseignement connaissent la valeur des méthodes pédagogiques traditionnelles, toutefois la qualité de l'enseignement peut être améliorée par la participation active des étudiantes. Comment favoriser cette participation dans l'étude de cas concrets et dans celle d'un incident déterminé? Voilà ce que l'université McMaster s'est efforcé de démontrer dans un cours donné récemment par Lucy Beal, de l'université de Boston.

La méthode d'enseignement par l'étude de cas concrets, développe chez l'étudiante l'esprit d'analyse, elle lui permet de travailler avec d'autres à résoudre un problème et d'accepter la solution pratique qui s'impose. Une étude de cas réunit tous les faits d'une situation concrète — quelque chose qui est arrivé à quelqu'un — et grâce à ces observations le résultat qui a pu être obtenu.

Les étudiantes reçoivent, bien avant les cours, une copie du cas mis à l'étude. Durant la classe, elles l'analysent graduellement. Par cette méthode elles apprennent à travailler en groupe, à connaître les préjugés et les opinions et à trouver une solution générale et pratique.

La méthode des incidents ressemble à celle des études de cas, mais comme son nom l'indique il n'y a qu'un incident de l'histoire de cas qui est présenté à la classe par l'ins-

titutrice. Une partie de la classe a préparé un rapport complet du cas auquel se rapporte l'incident. L'autre partie de la classe essaye, en questionnant le chef de groupe, d'obtenir le plus de renseignements possible. Après avoir évalué et classifié les renseignements obtenus, une décision raisonnable est prise par les deux groupes — cette méthode rappelle les combats des classes de notre enfance. Sa plus grande valeur réside peut-être dans le fait d'apprendre à l'élève qu'aucune décision ne doit être prise sans avoir une connaissance complète des faits.

Parmi les institutrices qui assistaient aux cours de l'Université de McMaster quelques-unes ont essayé cette méthode dès leur retour. Nous attendons avec intérêt le résultat de leur enseignement.

Ce que l'on dit . . . des infirmières

Le deuxième numéro de "Ce que l'on dit des Infirmières," vient d'être distribué; vous le trouverez dans les écoles d'infirmières, au bureau des Associations provinciales et ailleurs. Les infirmières désirant en obtenir un exemplaire n'ont qu'à écrire au Secrétariat national.

Ce que l'on dit . . . des Infirmières est une compilation des articles parus dans les différents journaux du pays. En plus de nous renseigner, ces nouvelles nous font réfléchir. Qu'est-ce qu'il y a au fond de ces histoires de journaux? Qu'est-ce qui a bien pu provoquer cela? Qui a bien pu écrire cela? Comment est-ce parvenu à la presse?

Tout ce qui apparaît sur la profession dans les journaux est d'un intérêt pour les infirmières car c'est ainsi que le public est renseigné. Le malade à l'hôpital bénéficie du service de l'infirmière sans toutefois se rendre compte de tous les plans de toute l'organisation nécessaire à cette fin. De même nous lisons les journaux sans nous rendre compte de toute l'organisation que demande la publication des nouvelles.

A la tête du Journal, il y a le propriétaire, c'est lui qui donne la ligne de conduite qui crée l'esprit du journal, ordinairement il délègue son autorité à un ou plusieurs rédacteurs qui sont chargés de donner l'opinion du journal sur tel ou tel événement, et de choisir les nouvelles et les photos devant être publiées. Le chef des nouvelles dirige le personnel qui rapporte les événements d'un quartier de la ville, ou d'un caractère particulier. Les reporters relèvent directement des chefs des nouvelles qui décident de la valeur du fait rapporté et de la façon dont il doit être écrit.

Les nouvelles sur les infirmières prennent naissance à plusieurs sources. Le plus grand nombre en est fourni par le travail des infirmières dans les hôpitaux, les agences de santé, l'industrie et à domicile. Lorsqu'un événement est jugé intéressant pour le journal un reporter est envoyé sur les lieux. Par contre, certaines nouvelles sont publiées grâce à l'initiative du journaliste. Un reporter peut suggérer à sa ou à son chef un fait se rapportant au nursing, qui fera une bonne nouvelle ou encore c'est le chef des nouvelles qui peut demander au reporter de préparer un article sur ce sujet. Enfin, les nouvelles peuvent être préparées au secrétariat national.

Un fait important à noter, est que tout ce qui se donne à la radio ou paraît à la télévision a son origine dans la presse.

Le journal de votre ville et le poste de radio de votre région ont une influence considérable. Essayez de coopérer avec les reporters.

Les anciennes qui n'ont plus d'Alma Mater

Trois années se sont déjà écoulées depuis que la première école d'infirmière du Canada vraiment indépendante a fermé ses portes. L'école du Metropolitan School of Nursing, qui avait pour but de démontrer combien il était plus facile de former des infirmières lorsque l'on ne compte pas sur les étudiantes pour assurer le service des malades, n'est plus. Les 87 diplômées de cette école qui ont fait leur cours durant une période de deux ans, sont certainement encore en service actif, mais elles n'ont plus d'Alma Mater.

Un questionnaire a été envoyé à chaque diplômée de l'école, 60 des 87 ont répondu. Plus tard un rapport sur les manifestations d'activité de ces infirmières sera préparé. Déjà des choses intéressantes se dégagent de ces réponses, l'une se croit handicapée du fait que son cours a été de moins de trois ans. D'autres disent du fait que l'enseignement a porté surtout sur les grands principes du nursing, qu'elles se sont adaptées facilement à toutes les situations où elles se sont trouvées.

Parmi elles environ 50% donnent des soins aux malades, 22 dans les hôpitaux et cinq en service privé. Près de 20% sont en hygiène publique en nombre égal dans les services de santé officiels et dans le V.O.N. comme infirmières visiteuses.

Vingt-quatre ont poursuivi leurs études en suivant des cours postscolaires dans les universités ou dans les hôpitaux.

Ce que nous pouvons apprendre des autres pays

Le Comité du Service au malades du Conseil International des Infirmières a proposé que des normes dans le service des malades pouvant être généralement acceptées, soient préparées pour diverses catégories de malades, ou pour certaines spécialités en nursing. Il a été suggéré que diverses Associations telles que l'Association des Infirmières Canadiennes préparent un travail pour un groupe particulier.

La réalisation de ce projet permettra d'étudier la qualité des soins et les méthodes employées à travers le monde. Les pays où le Nursing est moins avancé bénéficiant de l'expérience des autres. Treize pays ont déjà préparé des travaux, lesquels sont envoyés d'un pays à l'autre pour étude et critique. Chaque pays ajoute les suggestions qu'il propose.

Le secrétariat national a reçu à date un travail sur le Nursing pédiatrique, industriel, psychiatrique et de la tuberculose. Un comité sera formé pour donner l'opinion des infirmières canadiennes sur le sujet proposé, à savoir: le nursing en orthopédie et en poliomyélite.

Ce travail fait sur des bases internationales est une preuve de plus de la nécessité d'une coopération étroite entre les pays et du travail d'équipe. Aucun groupe, infirmière ou autre, ne peut donner à lui seul des soins complets à un cas d'orthopédie. L'expérience de plusieurs infirmières est nécessaire, puisqu'il faut envisager la prévention, les soins, la réhabilitation physique et mentale.

Et le déménagement?

Il va bon train à notre nouvelle résidence, 270 Laurier, ouest, Ottawa: les caisses s'ouvrent, les dossiers se rangent, votre secrétariat s'organise.

Un groupe d'infirmières mariées, résidant à Ottawa, vont nous prêter leur concours pour meubler les bureaux, recevoir les invités de l'A.I.C. Nous apprécions ce geste.

La prochaine réunion du Comité exécutif de l'A.I.C. aura lieu les 17, 18 et 19 février. Les deux grands comités du Service du Nursing et de l'Education en nursing tiendront leur assemblée à la même date.

QUELLES SONT LES CHANCES DE SURVIE DU PRÉMATURÉ?

Le prématuré qui survit demeurera-t-il une charge constante à la société? Comme enfant, comme adulte, sera-t-il souvent malade, hospitalisé? Son adaptation dans la société sera-t-elle plus difficile que celle d'un enfant né à terme. En d'autres termes, une femme médecin anglaise se demande si tous nos efforts pour conserver la vie aux prématurés ne sont pas vains? Sa réponse est basée sur une étude faite sur 10,000 prématurés d'une ville d'Angleterre, puis sur les recherches faites depuis plusieurs années en Suède, Norvège et Grande-Bretagne.

Elles trouve que c'est dans les trois premières années que le prématuré est plus exposé, à cette époque de sa vie il est plus sensible à l'infection et le taux de mortalité est plus élevé que chez les enfants nés à terme. Une fois cette période critique passée, les deux groupes, enfants nés prématurément et enfants nés à terme, se comparent avantageusement. Dans le groupe des prématurés, le poids et la taille sont moindres, le développement physique et mental un peu plus difficile. On se demande si le milieu social, la situation financière des parents, les soins médicaux ne sont pas des facteurs aussi importants à considérer dans le développement de l'enfant que sa naissance prématurée.

En général, d'après les différentes enquêtes, il est prouvé que les enfants nés prématurément réussissent aussi bien que les autres. Avec les progrès de l'obstétrique et de la pédiatrie, il y a moins de risques, de danger durant les trois premières années de vie.

D'après l'auteur, les prématurés bien constitués ont bien des chances de survivre et tout le mal que nous nous donnons n'est pas vain.

Is the Premature baby worth saving? V. M. Cross, *American Journal Public Health*, 44: 1000-1014, Aug. 1954.

I'd rather be a could-be
If I could not be an are;
For a could-be is a may-be,
With a chance of touching par;

I'd rather be a has-been,
Than a might-have-been, by far;
For a might-have-been has never been,
But a has was once an are.

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When your baby's hungry, he's hungry all over! His eyes dance, his mouth is eagerly open. You can *see* Pablum time is a happy time. And, as your doctor will tell you, a happy feeding time is important for Baby's health. Delicate flavour, and smoothness make Pablum* first choice with Baby, and you too, because it's pre-cooked for greater digestibility, contains vitamins, iron and other important minerals your baby needs when he's growing so fast. Just thin to Baby's taste with warm milk or formula. Choose his favourites from four delicious Pablum Cereals.—Mead Johnson & Company of Canada, Toronto, Belleville. *T.M. Reg'd.

Your doctor knows nutrition is our speciality

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MIXED CEREAL
BARLEY CEREAL
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Sélection

CENTRE DES PRÉMATURÉS

Au centre des prématurés du Jackson Memorial Hospital le "Veni, vidi, vici" se répète, mais cette fois prononcé par des infirmières. Répondant à l'appel fait à tous ceux qu'intéresse l'organisation d'un nouveau Centre de Prématurés, elles se rendirent à la réunion par curiosité et elles se rendirent compte que la survie des prématurés dépendait des soins donnés. S'y connaissant dans le domaine du Nursing, elles prirent une part active aux discussions.

Les infirmières, administratrices, surveillantes, hospitalières, service général, venant des services d'obstétrique, de pédiatrie de l'hôpital, des infirmières institutrices à l'école, des infirmières hygiénistes de l'unité sanitaire de comté et des médecins pédiatres et obstétriciens discutèrent la question. Comment prévenir l'infection fut le premier problème étudié. Le Comité décide d'appuyer sur la propreté et la bonne santé du personnel plutôt que sur les masques et la désinfection des mains.

La technique suivante fut approuvée: blouse à manches courtes (1 blouse différente pour chaque enfant) résille sur les cheveux et coiffe ordinaire, abandon du turban. Avant d'entrer à la pouponnière, dans un évier en dehors, lavage des mains, des bras et des coudes, 3 minutes (hexachlorophene 3/100) est employée. Les mains doivent être propres et bien soignées. Le poli sur les ongles a été l'objet d'une longue discussion.

Chaque membre du personnel du Centre subit un examen complet à l'embauchage et annuellement par la suite. Des frotis de la gorge sont faits tous les trois mois. Les aides, les bonnes subissent les mêmes examens. Tous les membres du personnel doivent rapporter immédiatement tout malaise. Elles sont alors renvoyées à la maison ou dirigées vers d'autres services.

Les blouses et tout le linge employé sont stérilisés. Au prématuré, dès qu'il peut être sorti de l'incubateur, des soins affectueux dont il a besoin plus que tout autre sont donnés. Durant les deux ou trois mois que le prématuré demeure à l'hôpital, il est pris et bercé (chaque pouponnière a sa chaise berceuse).

Tous les efforts sont faits pour que la même infirmière, substitut de la mère, donne ses soins aux mêmes enfants.

Dossier: deux feuilles forment le dossier de deux jours, sur la première d'un coup d'oeil le médecin peut lire tous les renseignements dont il a besoin, sur l'autre il prescrit.

Hygiène publique: le département de l'hygiène publique et l'hôpital travaillent en étroite coopération. La surveillante du centre rapporte au service d'hygiène les admissions quotidiennes. Une visite est faite à la famille par l'infirmière hygiéniste. Un rapport de la visite est envoyé à la surveillante du centre. Les départs sont aussi annoncés à l'infirmière hygiéniste qui visite la famille chaque jour jusqu'à ce qu'elle soit certaine que l'enfant reçoive les soins voulus. Les enfants sont surveillés par le médecin de famille, celui du service de santé ou de la clinique pédiatrique.

Le Comité attribue le succès de l'organisation à l'attitude démocratique de chacun lors des discussions.

Committee Planning Brings Results. D. E. Blackman et B. Perez; *The American Journal of Nursing*, Vol. 54, Sept. 1954.

* * *

Mlle Nightingale nous parle:

"Une femme qui ne voit dans la profession d'infirmière que le côté sentimental (qui se croit un ange de miséricorde) est plus qu'inutile; une femme qui croit se sacrifier ne réussira pas davantage et celle qui croit que tout le monde peut soigner un malade aussi bien qu'une infirmière ne peut que nuire."

"La véritable infirmière est celle qui a une vocation, un besoin de se dévouer pour ses semblables et elle se doit de répondre à cet appel."

Pour nous infirmières, si nous ne progressons pas chaque année, chaque mois, chaque jour, croyez-moi, nous reculerons. Plus nous avons d'expérience, plus nous devons progresser. Les progrès que vous réaliserez durant votre cours ne sont rien en comparaison de ceux que vous réaliserez après. Une étudiante qui se dirait une fois son cours terminé "maintenant je suis une véritable infirmière, une infirmière habile, j'ai appris tout ce qu'il y avait à apprendre", croyez-moi, elle ne sait pas ce qu'est une infirmière, elle ne le saura jamais, déjà elle a commencé à reculer.

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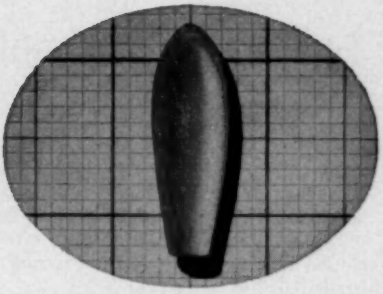

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Student Nurses

Tick Paralysis with Bulbar Involvement

ANN PATTINSON

INTRODUCTION

THIS PAPER ON TICK PARALYSIS has been prepared so that nurses may obtain a better understanding of a condition in which death is preventable if immediate detection and removal of the tick is achieved. Although this particular study deals with tick paralysis in which bulbar paralysis was present, all cases do not necessarily have bulbar involvement. However, it may ensue if the tick is not removed. It is of interest to note that in cases where the bulbar stage has been reached, recovery is rare. As far as can be ascertained, this is the first authenticated case of tick paralysis with bulbar involvement to recover in Canada. Only one such recovery has been reported in the United States in 1939. Thus, we see the importance of early recognition of the condition.

"Upon investigation of all cases of tick paralysis on record at the Dominion Medical and Veterinary Entomology Laboratory at Kamloops, B.C., as having occurred in British Columbia and the Northwestern United States, the following figures were obtained:

Known cases — B.C., 238
Known deaths — B.C., 27 or 11.3%
Known cases — U.S.A., 94
Known deaths — U.S.A., 12 or 12.7%
Known cases — Pacific Northwest, 332
Known deaths — Pacific Northwest, 39 or 11.7%

Causes of death are classified under three headings: Those cases not seen by a physician; those cases not seen until the terminal stage was reached; and those cases under medical care but in which a correct diagnosis was not made."*

Tick paralysis can affect all age groups, but is commoner in infants and young children. The species of tick responsible in the Pacific Northwest is *Dermacentor Andersoni* and although widely distributed, paralysis resulting from it is common only west of the Rocky Mountains. It must be remembered, however, that in this day of modern transportation, a tick infested person may travel far from this region in which tick paralysis is endemic. Hence a diagnosis of the condition should not be ruled out because tick paralysis is not characteristic of that region. There was one case in a prairie city during the early summer of 1953, in which the patient died from tick paralysis, having been in British Columbia prior to his illness.

THE TICK

The tick, once attached, may take from 7-10 days to become fully engorged at which time it will drop off. There is usually a lapse of approximately five days between the attachment of the tick and symptoms of paralysis. The actual mechanism by which the tick causes paralysis is not understood but extensive research is being conducted concerning this at the Entomology Laboratory in Kamloops.

Ticks are found between the months of February and August, but are most abundant in the months of April, May and June. Contrary to the widespread, erroneous belief that ticks fall onto a person from trees, actually they are found on grass and shrubs along animal trails, where they lie dormant and wait for passing animals or persons. When brushed against they attach themselves and rapidly climb up the

Miss Pattinson, while a senior student at the Royal Inland Hospital School of Nursing, Kamloops, B.C., prepared this valuable material.

*Rose, Ian, M.B., B.S. (London): "A Review of Tick Paralysis," *Canadian Medical Association Journal* 1954, pp. 175-76.

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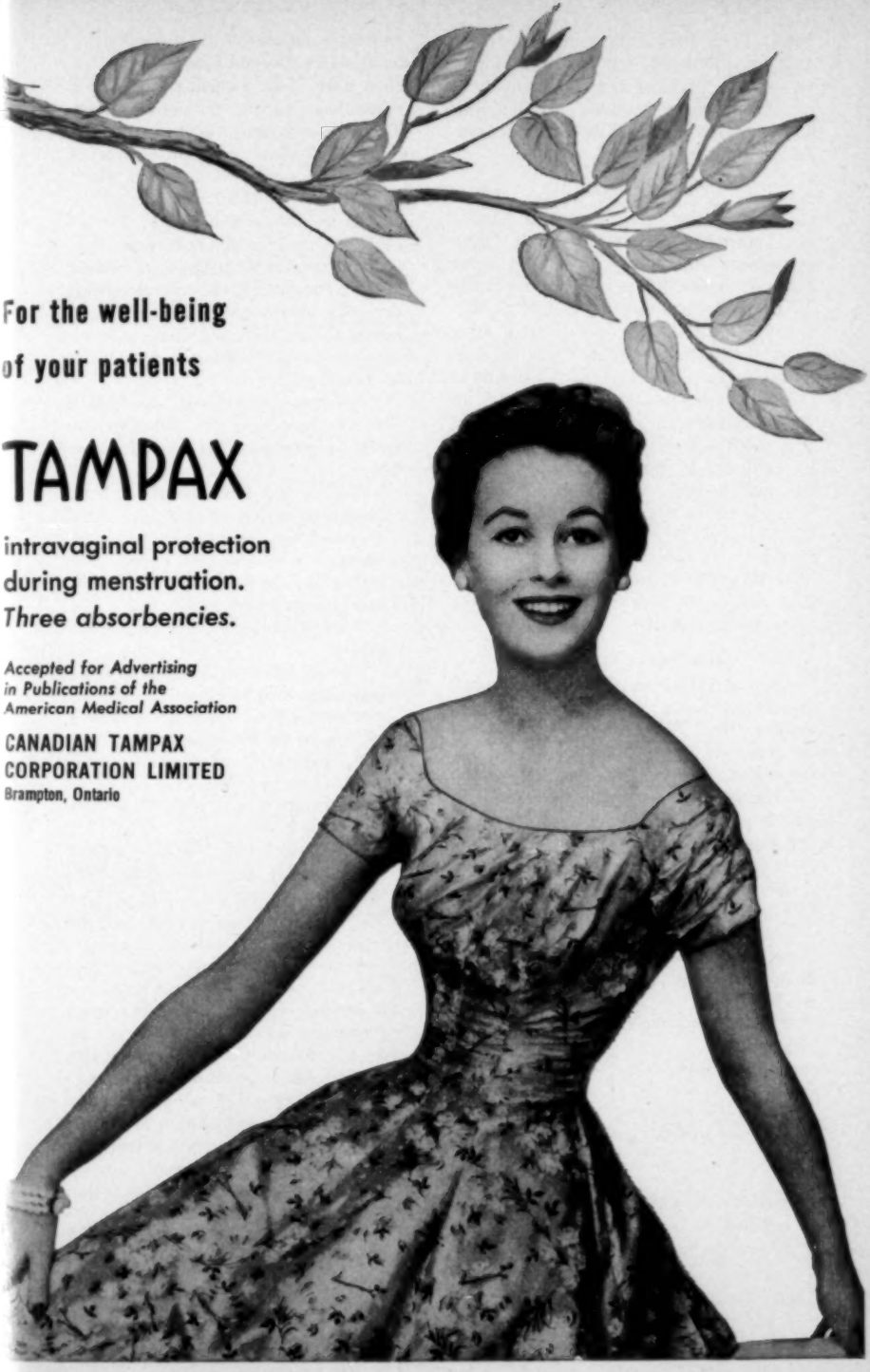

body. They may adhere firmly to any part of the body but the commonest site is the parietal region of the head or the neck just above the hairline. (Approximately 60-70% are discovered within these areas.)

Tick Paralysis

Prior to the onset of actual paralysis, there may be a period of vague complaints including irritability, pain or paresthesia in the lower extremities 12-24 hours before the onset of paralytic symptoms. The prodromal state does not always occur and the first symptoms may be those of the paralysis — which include staggering and incoordination of movements. Within a few hours lower extremity paralysis is evident. If not diagnosed, and if the tick is not removed, the paralysis spreads to the upper extremities within 12-24 hours. After this phase, progress is rapid. A bulbar paralysis develops with dysarthria, lingual, facial, ocular, and finally respiratory paralysis that may result in death.

Differentiation

Tick paralysis with bulbar involvement has been confused with bulbar poliomyelitis because of the similarity in some of the presenting symptoms. Therefore, an attempt has been made to differentiate between these two diseases:

Bulbar Poliomyelitis	Tick Paralysis
1. History of febrile illness.	1. None
2. Limited duration of development of paralysis.	2. Ascending progressive paralysis.
3. Meningeal symptoms.	3. None.
4. Anxiety.	4. None.
5. Paralysis of muscle group.	5. Symmetrical paralysis.
6. Mucular spasms.	6. Completely flaccid.
7. Sensory stimulation produces spasms.	7. Little or no response to sensory stimulation.
8. Urinary retention common.	8. None.
9. C.S.F. positive	9. C.S.F. no change.

Case History

Word was received that a three-year-old child was to be transferred from an outlying community with a diagnosis of bulbar polio. Preparations to receive the child were made, including those for a tracheotomy, suction, O_2 and respirator. The child apparently had been admitted to the hospital for treatment of a puncture wound caused by a nail at which time tetanus antitoxin had been given. It was understood that he had been in contact with a known polio case. Following treatment for the puncture wound in his right buttock, the child developed muscular twitching, progressing to paralysis of the limbs and finally respiratory involvement leading to a diagnosis of bulbar polio.

Kenneth was admitted on May 12 in a semi-conscious state. The following observations were made by those attending him:

Shallow, rapid respirations with no intercostal movement. This was demonstrated by placing both hands on either side of the child's chest and noting that the hands did not separate upon inspiration.

A large amount of thick mucus was present.

Flaccid, bilateral paralysis of arms, legs, abdominal and facial muscles including the third cranial nerve causing the eyes to move independently.

No meningeal symptoms were evident and anxiety was not present.

Temperature was 100⁴, Pulse 130, Respirations 26.

It appeared that the only muscle functioning in Kenneth's entire body was the diaphragm.

Following a cursory examination, the attending physician made an immediate diagnosis of tick paralysis. The partially engorged tick was recovered from the left parietal region of the child's head.

Treatment following removal of the tick was centred around good nursing care. Careful, close observation for any changes in pulse and respirations was extremely important. These were observed every 15 minutes and recorded hourly. It was necessary to use suction frequently as Kenneth had a large amount of mucus which tended to obstruct his air passages. He was placed in a Trendelenberg position to aid in draining the mucus. All external stimuli were kept at a minimum with the room as quiet as possible. Because he was in a semi-conscious state and unable to take

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fluids by mouth, an intravenous of 5% glucose in normal saline was started. S.R. Penicillin 400,000 units was given intramuscularly to prevent any possible secondary respiratory infection.

At 4:00 p.m., Kenneth became increasingly flushed and hot to touch. His temperature increased to 102° (R). The pulse rate was imperceptible. He lapsed into unconsciousness with his eyes rolled back. His color became cyanotic though no cyanosis of his fingernails was apparent. Oxygen was started by mask and his color gradually improved. The intravenous to which caffeine sodium benzoate, gr. 7½, had been added was discontinued and another of 1/3 saline and 2/3 glucose was started. This latter solution is helpful as it is an isotonic solution and will not upset acid balance which may occur in dehydration. It was thought at this time that the attack had been a convulsion occurring in a totally paralyzed person who, therefore, could not truly convulse.

Upon examination of the child at this time, there appeared to be beginnings of muscle tone in the legs and movement of the feet. Oxygen was discontinued and his color remained good. A bowel irrigation was given in an attempt to lower his temperature and relieve abdominal distension thus avoiding another seizure. Sodium luminal, gr. ½, was given intramuscularly for restlessness with fairly good effect.

Recovery

One hour after the removal of the tick, the muscle in Kenneth's arm twitched when the intravenous needle was introduced. About seven hours later tone began to return to the muscles of the extremities. It was interesting to observe that just as paralysis had progressed to muscles in ascending order, it receded in a similar fashion. On May 13, he was anxious to have a drink of water. This was tried, but was unsuccessful as he was still unable to swallow. However, he was able at this time to move his head from side to side and also to lift his right arm above his head. Two days after admission, he was able to grasp objects with his hand. Progress from this point on was rapid. Four days after removal of the tick, he was able to climb about in his crib although some weakness existed in his back which necessitated rolling himself on his stomach when he wished to raise up. In five days, he was able to walk. Some weakness of the back and neck persisted for a short time as these muscles were among the last to resume their normal functioning. He was placed on a clear fluid diet at first which he took very well. The diet was gradually increased to the regular diet for a child of his age.

Convalescence

On the morning of the 14th, Kenneth asked for an "ice cream cone" and as he had been on a clear fluid diet, the doctor was telephoned and an order received. He took the ice cream eagerly and there was no increase in mucus nor difficulty in swallowing.

During his convalescence Kenneth wanted company. This was complicated by the fact that he had been admitted to a single room apart from our pediatrics ward because of his provisional diagnosis of bulbar polio. In an attempt to overcome his feeling of loneliness, a go-cart was obtained in which he could be given rides and placed where he could see the staff passing back and forth.

He was always eager to see his parents who visited him at intervals. They cooperated in every possible way to help speed the recovery of their small son. Toys suitable for his age were provided and he took keen interest in them.

Kenneth was a bright child, keenly interested in all that went on around him. It was most gratifying to watch his progress during his stay in hospital. His many questions and requests for rides became part of the daily routine. It was with joy and gratitude that we saw the little fellow walk out of the hospital on May 18 with two very happy parents.

Summary

In conclusion, I would like to emphasize the importance of examination of patients for ticks in any case of paralysis of doubtful etiology. The areas in which ticks may be found are the head, neck, axilla, groin, vagina, ears and trunk.

Although for years people have been chasing ticks with hot needles and coal oil in an attempt to remove them, the surest way to get them out is simply to pull the tick out with one's fingers. Experiments with over 1,500 ticks at

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the Kamloops Entomology Laboratory have shown that the heads and bodies *do not separate.*

Another important thing to remember concerning ticks is that just because one tick is found and removed, the search should not end. A thorough examination for more ticks should be made. It should be noted that the *Dermacentor Andersoni* is also capable of transmitting Rocky Mountain spotted fever east of the Rocky Mountains, while yet another tick, the *Arnithodorus Maubota* may cause relapsing or African tick fever which are rickettsial diseases.

It would be greatly appreciated if any ticks (which have been removed from individuals with paralysis) would be sent to the Dominion Entomology Laboratory at Kamloops as an aid to the present research program being conducted by Mr. Jack Gregson and Dr. Ian Rose.

Book Reviews

The Epidemiology of Health — a New York Academy of Medicine Book, edited by Iago Galdston, M.D. 197 pages. Health Education Council, 10 Downing St., New York City 14. 1953. Price $4.00. *Reviewed by E. A. Electa MacLennan, Director, School of Nursing, Dalhousie University, Halifax.*

This is a series of lectures given by various specialists. Each contributor is an authority in his field and his approach to the public health aspects of these problems carries a great deal of weight by virtue of his reputation in the curative field.

As I read, I felt as if I were being given a glimpse into the future — a future where the emphasis in medical thinking would be not on pathological conditions but on the promotion of health. We are just beginning to feel at home with the word "epidemiology" in our public health conferences, where we usually infer the rest of the thought to be "of Disease." The concept of an "Epidemiology of Health" takes us one step forward in our thinking and planning concerning health programs.

If space permitted I would like to quote at length from each of the chapters, However, a few sentences must suffice. In Chapter I — Dr. Galdston says "So deeply are we committed to the concept of epidemiology of disease, that it is difficult to disassociate it from the concept of the epidemiology of health. The inclination is to think of the epidemiology of health as merely the mirror side of the epidemiology of disease. The epidemiology of disease rests upon pathology and its associated sciences of bacteriology and toxicology while the epidemiology of health rests upon normal physiology and its associated sciences of growth, development and performance."

The titles of some of the chapters give an indication of the scope of the material — "What is Health? — Looking Back and Ahead," "The Epidemiology of Health in Industry," "Mental Hygiene — Fundamental to a Dynamic Epidemiology of Health," "The Epidemiology of Nutrition," "Old Age: The Application of the Epidemiology of Health and its Medical and Social Problems."

"Epidemiology has for a long time carried the connotation of mass disease — though the word itself simply denotes study and knowledge of groups or crowds. This book clearly presents us with the concept of the health mass. More than that, it offers practical suggestions on how the objective of health in the mass can be effectively achieved." If this concept is applied to medical practice and education, as discussed in Chapter 12, definitely a new day will dawn for the general practitioner. "It should qualify him to see the patient in his setting, to see the whole situation confronting the patient and to give wise personal guidance. It should qualify him to be a penetrating diagnostician . . ."

There is a valuable appendix of notes and references for the reader who is interested in the source of the many apparently dogmatic statements which necessarily characterize a review of so comprehensive a field as the health of mankind. The book will arouse one's appreciation of the subject rather than being a textbook in the subject matter of epidemiology. As stated by Dr. Galdston, "It is descriptive of precisely the very core and essence of social medicine."

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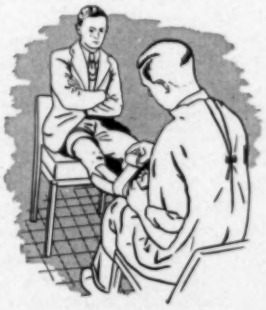

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Pediatric Nursing, by Gladys S. Benz, R.N. 624 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 7. 2nd Ed. 1953. Price $5.25.

Reviewed by Margaret Cawsey, Clinical Instructor in Pediatrics, University of Alberta Hospital, Edmonton.

The author states in the preface to this second edition that she has tried to (1) illustrate some of the reasons why each child must be treated as an individual, as a whole person with a definite place in the community, (2) beckon the student on to further exploration of the many facets of child care, (3) show how previous experience forms the foundation for pediatric nursing and (4) suggest how the nurse as a person affects the care given. All of these aims have been accomplished to some extent and therein lies the value of this book.

The book is arranged in "Unit" divisions. Chapters 15, 16 and 17 of Unit IV — "Developing Skills in Child Care" — deal with the application of previous experience, understanding the child, obtaining the child's confidence, some mental health principles and development of emotional stability. Summaries of two situations, one concerning the visit of a child to a clinic, the other, a visit to a private physician, illustrate the many problems in any encounter involving families. The child is an individual, but cannot be treated without considering his family and the total physical, emotional and social environment.

As additional reading this book could be an asset to the student nurse's library. It would stimulate a great deal of thought helping to orient the student to the extensiveness of pediatric nursing. As a textbook this wide coverage is a detracting factor. Specific pediatric conditions are very briefly covered.

Manual for Student Nurse Recruiters. 68 pages. Committee on Careers, National League for Nursing, 2 Park Ave., New York 16. 1953. Price 75 cts.

Reviewed by R. Catherine Aikin, Associate Director of Nursing Education, General Hospital, Calgary, Alta.

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It is obvious that a great deal of time and thought went into preparation of this manual. The ideas and suggestions were gathered from reports and letters from individual recruiters; speeches and participant comments made during regional conferences; interviews and informal chats with members of recruitment committees. The practicality of the suggestions indicates that any recruiter will find new ideas for her program which can be adapted to her own community needs and resources.

The section on organization stresses the necessity of first appraising the needs of the community and then planning the kind of organization which is best suited to the particular situation. Valuable suggestions are made concerning approaches to the problem.

This is an American Manual but it has definite value for recruitment in Canada. It could serve as a guide in setting up any committee's own manual. I would certainly recommend that every recruitment committee study its contents carefully.

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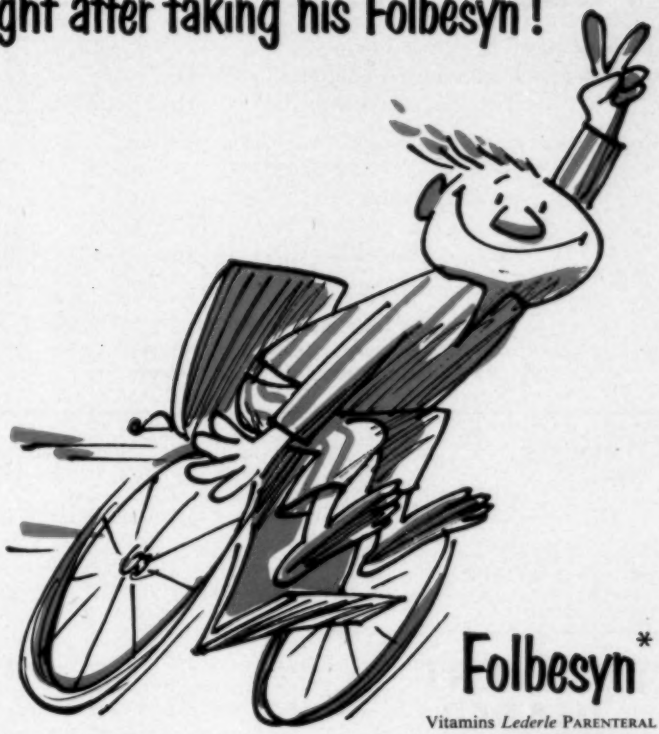

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Irritating diaper rash is caused by ammonia which is produced by bacteria. The result is that the wet diaper soon becomes like an acid-soaked pad against baby's tender skin. A few drops of Diaparene Rinse (does not contain boric acid) added to the final rinse water will stop dangerous bacteria from forming and your baby will have day and night antiseptic protection. Also, Diaparene prevents diaper odor.

If your baby already has a rash, use Diaparene Ointment liberally on the affected parts. At every diaper change use Diaparene *Antiseptic* Dusting Powder to ensure baby's complete comfort and protection.

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The first hour in the day nearly always sets the tempo for the entire day. If you start the day a little behind time it is very likely that you will never catch up all day. Much of the sense of hurry and pressure could be eliminated by a simple expedient.

Everyone has his own best pace or tempo for doing things. When we give in to hurry we allow external things and situations to set our pace for us. This is always a mistake, whether in the field of sports or the game of life. Set your own pace; play your own game.

Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

Appointments — *Ruth Armstrong,* formerly with Muskoka District Health Unit, *Nancy (Anderson) Henry* (Hosp. for Sick Children, Toronto, Univ. of Toronto gen. course), *Madalyn (Holmes) Montgomery* (Toronto West. Hosp., U. of T. gen. course), all to North York Township Board of Health. *Coleen (Birmingham) Barber* (St.

Jos. Hosp., Hamilton, Univ. of Western Ontario cert. course) to Niagara Falls B. of H. *Betty (Mitchell) Buckley* (St. Jos. Hosp., London, U.W.O. cert. course) to York County H. U. *Adele (Rogers) Dockstadder* (Toronto Gen. Hosp., U. of T. gen. course) to Welland and District H. U. *Fenna Dykstra* (Deaconesses' Institution, Univ. of Groningen, Holland) to Chatham B. of H. *Alice Klugman,* formerly with Windsor Dept. of Health to Etobicoke Township B. of H. *Jennie (Tabacki) Legris,* Hamilton Gen. Hosp., U. of T. gen. course) and *Marion Beger* (Royal Victoria Hosp., Montreal, U. of T. gen. course), both to Stormont, Dundas and Glengarry H. U. *Margaret Veit* (T.G.H., U. of T. gen. course) to Peterborough B. of H. *Dorothy Wick,* formerly with Huron County H. U., to York Township B. of H.

Resignations — *Kathleen Bayley,* as supervisor, and *Thelma Pritchard,* staff, both from Ottawa B. of H. *Laura Bowen* and *Margaret Tanney,* both from Stormont, Dundas and Glengarry H. U. *Elizabeth (Turbitt) Bushlen* from Brant County H. U. *Phyllis (Keep) Scott* from Fort William and District H. U.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Halifax: *Mrs. Kaireen Allen* (Montreal Gen. Hosp.). Moncton: *Helen Lois Parks* (Saint John Gen. Hosp., N.B.). Surrey: *Inga Jensen* (Misericordia Hosp., Edmonton).

Transfers—In charge: *Katherine Gannon* from Niagara Falls to St. John's, Nfld.; *Georgie Gratto* from Bridgewater to Amherst, N.S.

Nursing Sisters' Association Montreal Unit

Nursing Sisters of World War I were guests of those of World War II at a Christmas card party in the nurses' quarters at Queen Mary Veterans Hospital. The president, Miss E. Groenewold, assisted by Mrs. E. McNaughton, presented the prizes. A visit from Santa Claus was one of the features of the evening.

Even mild or occasional constipation takes a heavy toll of a nurse's energy.

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MONTREAL CANADA

News Notes

ALBERTA

District 2

Camrose

Twenty-six members attended the November meeting of the chapter when it was reported that a profit of $281.09 was realized from the Nightingale dance. Plans were made for a Christmas party in the form of a buffet supper and donations of 50 cents from each member in support of the Merry Christmas fund. It was decided to run a monthly item in the local paper noting activities of general interest. A color film of the four seasons followed the business meeting.

Ponoka

Under the chairmanship of Mrs. J. Crowhurst at a recent district meeting, election of officers resulted as follows: President, Mrs. Crowhurst; vice-president, Mrs. E. Coombs; secretary-treasurer, M. Sundberg. Serving in other capacities are: A. La Plante, E. Kemp, I. Movell, P. McMillan, Mmes N. Kinnear, E. Clapp. V. Evans is the representative to *The Canadian Nurse*. Mrs. Kjar reported on the Well Baby clinic. Plans were made to invite Wetaskiwan Chapter to the Christmas party. It was decided to hold a rummage sale and a spring tea to augment the funds.

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BRITISH COLUMBIA

Trail

A. Baker, president, conducted the November meeting of the chapter when the resignation of D. Mawdsley as convener of the program committee was accepted with regret. An invitation from Rossland Chapter to attend their Silver Tea with district delegate, Nancy Lee, speaking on the C.N.A.

Biennial Convention in Banff was received. Mrs. Evans was chosen to place the wreath on Remembrance Day while Mmes R. Garland and F. Wilson volunteered to convene the Christmas party.

V. Eidt donated the nucleus of the new medical reference library in Trail-Tadanac Hospital for the use of the nurses and will convene the library committee, assisted by Mrs. Ross. $10 was given M. Rivett for her new projector fund in appreciation of the use of her slides. Plans for the annual ball, under the convenership of Mrs. Wilson, were discussed. Mrs. G. Morris is convener of the nominating committee. V. Eidt reported that the provincial legislative committee is working on the new R.N.A.B.C. By-Laws. After refreshments, Miss Rivett showed colored films of her trip to Britain and the continent.

VANCOUVER

St. Paul's Hospital

A carefully planned Christmas party with gifts for needy patients and the annual bazaar with booths of many kinds of articles where no prices were over a dollar, were among the projects of the alumnae association in December. The executive entertained the next graduating class at the annual dinner and presented trophies to two students chosen by their classmates as outstanding members.

MANITOBA

WINNIPEG

General Hospital

At the December meeting of the alumnae association, arrangements were made to pack hampers for needy nurses and to distribute gifts to members who were ill. The Nurses' Glee Club, conducted by Mr. G. Kent, and solo selections by other members provided a delightful musical evening.

NEW BRUNSWICK

MONCTON

The president, Mrs. Nash Smith, conducted recent meetings of the chapter. C. MacLeod, N. McGorman, and M. Johnston related their experiences at the C.N.A. Biennial Convention in Banff at one meeting and at the other a colored film of Canadian scenery and the Trans-Canada Airlines was shown at the conclusion of the business for the evening.

ONTARIO

DISTRICT 4

HAMILTON

D. Sharpe succeeded E. Ewart as chairman at the recent election of officers during the annual meeting of the district in Grimsby. Others elected were: Vice-chairmen, M. Campbell, P. Hobson; secretary-treasurer, H. Vohman and assistant, S. Brough; committee chairmen, H. Alderson, B. Grinham,

MALE NURSES' FUND

The late Dr. Thomas Dawson established a fund to assist young men who may be desirous of taking up the profession of Nursing to obtain their R.N. Degree in approved Schools of Nursing. The provisions of this fund provide that all applications for assistance must be made by the Hospital Superintendent who may recommend the male student and state that the student intends to complete the course through graduation. This fund will assist each student to a sum not exceeding $300.00 in aggregate and which will be advanced to the students at the rate of $50.00 at the completion of each six months of training.

For further information write to:

George E. Masters,
Administrator,
Royal Jubilee Hospital,
Victoria, B.C.

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The Association of Nurses of the Province of Quebec

The 1955 Spring Examinations for Provincial Registration will cover two groups of candidates, and will be held as follows:

EXAMINATIONS FOR REGISTRATION PART II

Graduates desiring to qualify for a license to practise will write on April 12th, 13th, and 14th, 1955. Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school. *Applications must be received by March 1st, 1955.*

EXAMINATIONS FOR REGISTRATION PART I

Students who will have completed their first year will enter the Examinations for Registration, Part I, which will be held on March 14th, 15th, 16th, and 17th, 1955. (Time to be announced in each school)

APPLICATIONS MUST BE RECEIVED BY FEBRUARY 10th, 1955

For application forms and all information relating to the examinations, apply to the headquarters of the Association:

A. WINONAH LINDSAY, R.N.
Secretary-Registrar.
Suite 506 - 1538 Sherbrooke St., West, Montreal 25, Que.

R. Brown, A. Fivey, D. Thompson, A. Kroeker, Misses Ewart, Campbell and Hobson, Mrs. D. Wilkerson; counsellors, E. Ferguson, M. Low, A. Oram, D. Scott, M. Hudson, Sr. Bonaventure, Mmes E. Lynn, L. Fauteaux. H. McGhee is the representative to *The Canadian Nurse*. I. Mayall presided at the elections.

District 5

Toronto

St. Michael's Hospital

K. Gies is hospital supervisor for the nursing assistant course at Queen E., Provincial Department of Health. I. Nealson, N. Bradley, and M. Shaver are attending Ottawa University. M. Jones is on the staff of Children's Hospital in Vancouver. M. Sullivan completed her course in nursing education at Seattle University and is attending the University of Washington for her Master's degree in nursing. L. Kane is taking a post-graduate course at the Montreal Neurological Institute. Mrs. E. (Nott) Lindsay is matron, and her husband manager, of the Grey County Home at Markdale.

Congratulations go to Sr. Maura, superintendent, and Sr. Honora, assistant administrator of St. Michael's, on the award of certificates of membership and to Sr. M. Louise, superintendent of St. Joseph's Hospital, Toronto, for the certificate of Fellowship by the Board of Regents at the annual convention of the American College of Hospital Administration, Chicago.

Women's College Hospital

M. Robins has returned to the staff after completion of her post-graduate studies in London, Eng. J. Good is nursing in Cleveland while S. Yashimura is in Copper Cliff, Ont. H. Snider, B. Newsome, and R. Watson were among the five volunteer nurses who helped with typhoid injections in Weston during the flood. M. Mills is in Scotland.

District 8

Ottawa

Civic Hospital

Tours of the new nursing education building were of interest to members of the alumnae association following recent business meetings. The building is of the most modern type and has the finest up-to-date equipment. It has been decided to present a Hammond electric organ to the chapel as a nurses' memorial gift. A committee under the chairmanship of E. Horsey was formed to propose ways and means of raising the required funds. Successful projects during the autumn were a rummage sale and a bridge party.

Among those who have joined hospital staffs recently are: J. Short, Sunnybrook Hospital, Toronto; D. Smith, East Lawn Pavilion, O.C.H.; E. McNaughton, King Edward VII Hospital, Bermuda; M. Smith, Westminster Hospital, London, Ont.; J. Magladry, I. Comrie, and R. Adair, Prince Rupert General Hospital, B.C.

D. Ogilvie is taking a certificate course in public health nursing at the University of Toronto, M. Logan-Vencta is attending McGill University to obtain her B.Sc.N., while E. Doree has completed a public health nursing course at University of British Columbia. P. Whyte is with the Sudan Interior mission in Ethiopia while Lt. N/S M. Shaw has returned from a year of duty in Korea and Japan. E. Osborne of the faculty of the University of Manitoba spent the summer attending the Gerontological Congress in London, Eng., and completing her studies in gerontological problems in the Scandinavian countries.

General Hospital

The alumnae association of the hospital and university school of nursing were hostesses to the delegation of 40 nurses who came to Canada to attend the International Congress of Catholic Nurses in Quebec City. The $1,000 derived from the annual bazaar was added to the benefit fund for sick nurses.

G. Clarke is charge nurse of the antituberculosis clinic, K. Bayley, nursing counsellor for the Department of National Health and Welfare, and J. Sabourin, health nurse at the Parliament buildings. Miss Bayley, president of the Ottawa unit of the Nursing Sisters' Association of Canada, was presented to Her Majesty, Queen Mother Elizabeth, during her recent visit.

PEMBROKE

Cottage Hospital

Edna I. Sheppard who has been operating room supervisor since 1948 was appointed director of nurses recently. A graduate of Cornwall General Hospital, Miss Sheppard worked in hospitals in Newmarket and Chapleau prior to coming to Cottage Hospital.

QUEBEC

MONTREAL

Royal Victoria Hospital

Members of the 1955 graduating class were guests of honor at the annual Christmas tea of the alumnae association. Mrs. C. Sutherland reported on her trip as delegate to the C.N.A. Biennial Convention in Banff.

New members of Sydney Chapter present at the supper meeting held at Isle Royale Hotel recently were: J. Adams, superintendent of Harbour View Hospital, E. (MacKinnon) Coughlan, and M. S. (MacDonald) MacIntosh.

S. Harris is assistant head nurse, Ward G. M. Pedley is on the Jamaica and A. MacBeath on the overseas run of the T.C.A. J. (Hervey) Riley is supervisor of health service for employees at St. Mary's Hospital, Tucson, Arizona, while D. Robinson and H. Celinski are on the staff of the Miller Bay Hospital, Prince Rupert, and E. Murray, the staff of Shaughnessy Military Hospital, Vancouver. Recent word from E. Martin tells of her work in Ceylon with WHO. L. Beck, J. Kirk, and L. Sheppard have resigned from staff.

A H

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INDICATIONS: Vaginitis (trichomonas, monilia, and mixed flora) Pruritus and leucorrhoea.

COMPOSITION:

Sodium Propionate	20 %
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Effective acid pH	

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Vaginal suppositories: Box of 12
Cream: Tube of 3 ounces with applicator

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Head Nurse for Surgical Floor, also **Graduate Nurses for general staff duty in Paediatrics, Medical and Surgical, Emergency,** immediately. Excellent working conditions; no split shifts; 44-hr. week; additional premium for 3:00 p.m. — 11:00 p.m. shift. Apply, giving past experience and references, to **Director of Nursing Services,** South Waterloo Memorial Hospital, Galt, Ont.

Head Instructor for Training School to teach Sciences. 86-bed hospital; 30 students. Complete maintenance provided in comfortable suite. Apply, stating qualifications & salary expected, A. J. Schmiedl, Sec.-Manager, General Hospital, Dauphin, Man.

Night Supervisor, Head Nurses & General Duty Nurses for 147-bed Medical & Surgical Sanatorium. Salary dependent upon experience & qualifications. Residence accommodation if desired; transportation arrangements for those living out; 1 mo. vacation annually, sick benefits, etc.; time allowed for university study. For full particulars, apply Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke St. E., Montreal 5, Quebec.

General Supervisors, Charge Nurses & General Duty Nurses for new 150-bed hospital. Starting salary for General Duty Nurses — $220 for B.C. Registered, with annual increases up to $30. 40-hr. wk. 1½ days cumulative sick leave. 28 days vacation. 11 statutory holidays. Apply Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

Occupational Therapist (female) for 900-bed hospital. The duties of this post consist of taking charge of occupational therapy in the female department which has a modern central occupational therapy dept. that gives supervision to ward occupational therapy, and operates in liaison with the dept. of recreational therapy. Applicants should have specific training in occupational therapy and preference will be given to those whose training has oriented them in the field of psychiatry. Salary is on the scale: $2800-100-3000 per annum; board and lodgings are available in modern Nurses' home for $40.00 monthly, deductible from salary, and uniforms and laundry services are provided. Passage will be paid to St. John's. Applications, including qualifications and experience, should be addressed to: C. H. Pottle, M.D., Supt., Hospital for Mental and Nervous Diseases, St. John's, Newfoundland, Canada.

Science Instructor; Operating Room Supervisor — experienced, preferably with post-graduate course — and **Charge Nurse** for new 100-bed hospital. Salaries open. Apply Supt., Charlotte County Hospital, St. Stephen, N.B.

The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

NURSING ARTS INSTRUCTOR

CLINICAL INSTRUCTOR FOR PEDIATRICS

In New Hospital Capacity 266 beds

Salary $300 to $350 per month depending on qualifications; Liberal Personnel Policies

Apply: Personnel Director, Sarnia General Hospital, Sarnia, Ontario.

Instructors for: Science Teaching followed by Clinical Ward Teaching; Clinical Ward Teaching & lectures in Medical Nursing. Commencing salary: $250 (additional for experience). Current R.N.A.B.C. contract in effect. 65 students; one class per yr. For information about position & community apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Public Health Nurse — Grade I — British Columbia Civil Service, Dept. of Health & Welfare. Starting salary: $255-260-266 per mo., depending on experience, rising to $298. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in B.C. & have completed University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of province.) Cars are provided; 5-day wk. in most districts; uniform allowance. Candidates must be British subjects, under 40 yrs. of age, except in case of ex-service women who are given preference. Further information may be obtained from Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C. Application forms obtainable from all Govt. agencies, Civil Service Commission, Weiler Bldg., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Victoria, B.C.

Public Health Nurses for generalized program in rural-suburban Health Unit near Toronto. Minimum salary: $3,000; pension plan. For full details apply Supervisor, Peel County Health Unit, Court House, Brampton, Ont.

Operating Room & General Staff Nurses for 155-bed Acute General Hospital, located in famed San Joaquin Valley. Starting salary: $275 per mo. — $10 monthly differential in surgery; regularly scheduled increases; 40-hr., 5-day wk; 2 wks. paid vacation after 1st yr.; 3 wks. after 3 yrs.; 1 mo. after 5 yrs; travel expenses refunded after 1 yr. employment. Write Administrator, Community Hospital, 1234 "S" St., Fresno 1, California.

Charge and General Duty Nurses for 80-bed general hospital. Good personnel policies. Apply Director of Nursing, Parry Sound General Hospital, Parry Sound, Ontario.

Graduate nurses for General Staff Duty. Inquiries are invited for these positions in Vancouver General Hospital. 40-hr. wk. Salary: $231 per mo. minimum & $268.50 maximum, plus shift differential for evening & night duty; temporary residence accommodation is available. Applications should be accompanied by letter of acceptance of registration in B.C. from Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., General Hospital, Vancouver 9, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, Matron, Terrace & District Hospital, Terrace, British Columbia.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

HOSPITAL NURSES

GRADE 1 — $2,430-$2,820 GRADE 2 — $2,730-$3,120

Department of Veterans Affairs Hospitals

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Westminster, London	Shaughnessy, Vancouver

Application forms, available at your nearest Civil Service Commission Office, National Employment Office or Post Office, should be filed with The Civil Service Commission, Ottawa.

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Matron, to commence duties Feb. 15, if possible, for 18-bed hospital, to take charge of staff consisting of 5 Graduate Nurses, 2 Ward Aids and 4 other personnel. 2 nurses and 1 Ward Aid at present living in. Salary $260 per mo. less $35 for maintenance, living accommodation at present in hospital. New nurses' residence soon to be constructed. Fare refunded after one yr. service, 28 holidays per yr., and statutory holidays. 40-hr. wk. Attractive community and social life; modern theatre, curling, skating, skiing, badminton, tennis etc. Apply V. H. Collins, Sec. Treas., Golden General Hospital, Golden, B.C.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & post-graduate program. Full Maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Operating Room Nurse immediately. Salary commensurate with training. Also **Registered Nurses and Maternity Nurses,** salary: $150 and $105 respectively with full maintenance. Small general hospital; 44-hr. wk.; 8 hr. duty; rotating shifts; Blue Cross and many other benefits. Apply Lady Superintendent, Barrie Memorial Hospital, Ormstown, Que.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information, apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec.

Graduate Nurses offered a six-month post-graduate course in Tuberculosis. Maintenance and salary as for general staff nurses; opportunity for permanent employment if desired. Spring and fall classes. For further information apply Baker Memorial Sanatorium, Calgary, Alberta.

Registered Nurses for 60-bed hospital, starting salary $160 plus full maintenance. 8-hr. duty; 28 days vacation; pleasant surroundings with excellent residence across from hospital; increment after 1 yr. service for 3-yrs. Apply Supt. of Nurses, Alexandra Marine & General Hospital, Goderich, Ont.

Registered and Non-Registered Nurses, General Duty. Salaries: Registered Nurses, $160. per mo. with full maintenance; others according to experience; 8-hr. rotating shifts with 1 day off each wk. and an extra day every second wk. Vacation and sick allowance — each 1 and ½ days monthly. Complete new hospital unit under construction. Apply: Supt., Lady Minto Hospital, Cochrane, Ont.

General Duty Nurses (4) — Registered or Graduate — for 45-bed hospital. 8-hr. shift; 48-hr. wk. Salary: $210 per mo. gross. Increase of $5.00 per mo. after 6 mos. service. 3 wks. holiday with pay after 1 yr. service. Modern nurses' residence. Transportation refunded. Daily bus facilities to North Battleford & Saskatoon. Apply Matron, Union Hospital, Meadow Lake, Sask.

School of Nursing, Metropolitan General Hospital

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Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

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Registered Nurses for 398-bed non-sectarian general hospital with School of Nursing, full or part-time. Excellent opportunity for study at nearby Western Reserve University. Starting salary: $240-260, based on experience, plus $1.00 per diem for evening or night duty. **Operating Room Nurses** $10 per mo. additional; two weeks vacation; 6 holidays; 10 days sick leave. We will assist you in finding living accommodations. For detailed personnel policies write: Director of Nursing, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio.

Graduate Nurses for completely modern West Coast hospital. Salary: $230. per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after first yr. Also **Evening Supervisor,** 4-12, salary commences at $265. Also **Charge Nurse,** 25-bed ward combined female surgery and obstetrics. Salary commences at $265. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, British Columbia.

Clinical Instructor for Nursing Arts, Pediatric Area in Modern 400-bed hospital. Salary commensurate with experience; applications are now being considered. Address correspondence to: Director of Nursing, Kitchener-Waterloo Hospital, Kitchener, Ont.

Maternity Nurses for small general hospital. Salary $105 with full maintenance; 44-hr. wk; 8-hr. duty; rotating shifts; yearly increments and other benefits. Apply, Lady Supt., Barrie Memorial Hospital, Ormstown, Que.

General Duty Nurses and **Supervisor for 3:00 p.m. to 11:00 p.m.** to complete staff in new hospital. Good salary and personnel policies. Apply: Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

General Duty Nurses for 430-bed hospital. Salary: $230-260. Credit for past experience. Annual increments. 40-hr. wk. Statutory holidays; 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty Nurses for 200-bed general hospital with all graduate staff. Salary: $11 ($240) to $12.60 ($277.20) per day; 40-hr. wk.; p.m. and night bonus; usual paid benefits; credit given for previous experience; promotions made from staff; quarters available next to hospital at $18 per mo.; excellent transportation to all areas. Send snapshot, references, and state qualifications. Each letter will be given my individual attention. Send applications to: Director of Nurses, Doctors Hospital, 12345 Cedar Road, Cleveland, Ohio, U.S.A.

General Duty Graduate Nurses for 70-bed acute General Hospital situated 200 miles northwest of Vancouver on the B.C. coast. Salary $222 per mo. plus four semi-annual increments; 4 wks. holidays plus 10 statutory holidays after 1 yr. Transportation advanced if desired. Apply: Matron, St. George's Hospital, Alert Bay, B.C.

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OBSTETRICS SUPERVISOR AND INSTRUCTOR
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Gross salary commensurate with experience, 28 days vacation after one year, 8 statutory holidays, sick leave accumulative to 60 days; Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped and staffed wing with extensive renovation program progressing in the old section.

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Registered Nurses (2) for fully modern 30-bed hospital. Salary: $175 per mo. with full maintenance and increases; separate living quarters; usual vacation schedule and all statutory holidays. Apply: Robert G. Keast, Sec.-Treas., Roblin District Hospital, Roblin, Manitoba.

Operating Room Nurse with Post-Graduate Training. For full particulars apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec.

Staff Nurses for 600-bed General Hospital with School of Nursing. Salary: $273-322. Shift & education differentials. 40-hr. wk. 12 holidays; cumulative sick leave; 3 wks. vacation. Apply Director of Nursing Service, General Hospital, Fresno, California.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

Science Instructor for School of Nursing of 200 students in 755-bed hospital. Duties to commence September 1, 1955. Applications to be made to Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Office Nurse for Wainwright Clinic, Wainwright, Alberta. State qualifications and salary expected.

General Duty Nurses for hospital 300 miles north of Vancouver, on the B.C. coast. Salary $215 per mo. less $40 maintenance; 2 annual increments of $5.00 per mo. Sick time 1½ days per mo. cumulative; 1 mo. annual holiday, plus 10 days in lieu of statutory holidays. Transportation to Bella Bella refunded after 1 yr. Apply: Matron, The R. W. Large Memorial Hospital of the United Church of Canada, Campbell Island P.O., Bella Bella, British Columbia.

Registered Nurses for 22-bed general community hospital at a friendly town in the Cariboo District, British Columbia. Starting salary $225 per mo., $235 after 6 mos., less $40 board and residence. 40-hr. wk.; one mo. vacation with full salary plus all statutory holidays. Transportation up to $60 refunded after 6 mos. service. Sick leave benefits; Apply, stating experience to Director of Nursing, Quesnel General Hospital, Quesnel, British Columbia.

General Duty Nurses (2) for modern 32-bed hospital. Single rooms in attached new residence; board and room $30. Starting salary $210 gross; semi-annual increments; four wks. annual vacation; 8 statutory holidays. Duties to begin March 1, if possible. Apply Union Hospital, Langenburg, Sask.

Registered Nurses (2) for 22-bed hospital, preferably with Operating Room experience. Good salary & reasonable maintenance. 44-hr. wk.; 28 days vacation with pay after 1 yr. service; 7 statutory holidays. Apply, giving qualifications & references, Bruce Peninsula & District Memorial Hospital, Wiarton, Ont.

Obstetrical Nurses (2) for Delivery Room in 30-bed Obstetrical Unit. Good Personnel policies. Hours to rotate from 7:00-3:30 and 11:00-7:00. Apply Director of Nursing, Belleville General Hospital, Belleville, Ont.

OPERATING ROOM NURSE

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Ste. Foy Hospital, Quebec City

Open to qualified residents of the Province of Quebec

Details and application forms obtainable at Post Office, National Employment Office or nearest Civil Service Commission Office.

Apply **IMMEDIATELY** to the Civil Service Commission, 685 Cathcart S., Montreal, P.Q.

Quote Competition No. 55-M2002.

Instructors for Science and **Nursing Arts Teaching;** — 80 students, one class a yr.; new hospital, good personnel policies; Salary dependent on qualifications and experience. For information apply Director of Nursing, Moncton Hospital, Moncton, N.B.

Registered Nurse, also **Certified Nursing Assistant,** duties to commence at once. Apply Shelburne District Hospital, Shelburne, Ontario.

Registered Nurses for General Duty in 50-bed hospital. Good Personnel Policies. Apply Supt., Cobourg General Hospital, Cobourg, Ont.

General Duty Nurses for modern 75-bed Hospital. Basic salary $170, plus maintenance. Apply Administrator, Dufferin Area Hospital, Orangeville, Ont.

Science Instructor, Clinical teachers for medical, surgical and urology depts. in 460-bed hospital, 160 students. Also **Staff Nurses and Dietitian.** Attractive personnel policies. Apply Director of Nurses, St. Joseph's Hospital, Victoria, B.C.

Head Nurse to take charge of busy surgical-medical floor (private and semi-private) in 142-bed general hospital. University preparation (or equivalent) and experience in ward supervision essential. Initial salary $250 to $260 or more, depending on experience. Good working conditions and personnel policies. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper St., Montreal, Que.

Operating Room Nurse (1); **General Duty Nurses** (3); and **Supervisor** for 3:00 to 11:00. for new 140-bed hospital with 32 bassinettes. Good salary and personnel policies. Please apply Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

Registered Nurse with Public Health qualifications to start immediately at the Stony Plain-Lac Ste. Anne Healh Unit No. 17, near Edmonton. Minimum salary $2,640 p.a. and increments $140 x 3 and $260 x 1. Starting salary by arrangement. Applications stating qualifications to the Director of the Health Unit, Stony Plain, Alberta.

Public Health Nurses (2) for generalized program in Alberta East Central Health Unit (Hughenden and Coronation sub offices). Provincial salary schedule; experience recognized up to 3 yrs.; annual increments; pension plan; Blue Cross available. For details apply Dr. D. Mackay, Medical Officer of Health, Stettler, Alberta.

Public Health Nurses (2) Salary according to qualifications; annual increments. Car provided, also living accommodation to single nurses. All benefits of Civil Servants. Apply C. R. Beggs, Secretary-Treasurer, Peace River Health Unit No. 21, Peace River, Alberta.

General Staff Nurse for Operating Room work, February 15, also **Graduate Nurses (2) for General Staff Work.** Hospital in Georgian Bay area — good working conditions. Apply: Director of Nursing, General and Marine Hospital, Owen Sound, Ontario.

Graduate Nurses (3) at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alberta.

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For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada,
193 Sparks Street, Ottawa 4, Ont.

Science Instructor for school of 180 students in 500-bed hospital. Degree in nursing preferred but not required. Apply to Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

Staff Nurses for 500-bed general hospital. 40-hr. wk. Beginning salary: $260. per mo. with advancement to $295; additional differential $1.50 per afternoon, $1.00 per night. Hospital and school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan, U.S.A.

Assistant Director of Nursing Service, qualified to direct and supervise patient care in 100-bed pediatric hospital. Applications to be accompanied by suitable names for reference and recent photo. For further particulars apply: Director of Nursing Service, Children's Hospital, 250 West 59th Ave., Vancouver 15, B.C.

General Duty Nurses for 12-bed hospital about 200 miles from Calgary; good train and bus service; 8-hr. day. Salary: $205 per mo. plus full maintenance. Two increases of $5.00 per mo. after each 6 mos. service. Apply: Sec. Treas., Cereal Municipal Hospital, Alberta.

Clinical Instructor, Medical & Surgical. Pre-requisite 1 yr. p.g. course in teaching & supervision. Allowance paid for degree, if experienced. Good salary & personnel policies. Apply Director of Nurses, Guelph General Hospital, Guelph, Ont.

Educational Director required May 1, for 548-bed hospital. Student Nurse affiliation and in-service staff educational program. Salary $260, with $10 semi-annual increments to $290. 40-hr. 5-day wk; pension scheme; living accommodation available. Apply, stating qualifications, experience, and references to Superintendent of Nurses, Winnipeg Municipal Hospitals, City of Winnipeg.

Pediatric Supervisor, immediately. Good salary and personnel policies. Accommodations available in residence. Write, stating qualifications and experience, to Director of Nurses, Welland County General Hospital, Welland, Ont.

Instructor in Sciences, including curriculum planning, **Clinical Instructor** in Medicine and **Clinical Instructor** in Surgery required for School of Nursing by August 1, 1955, in 177-bed hospital, affiliation arranged in T.B. nursing, Psychiatric Nursing and Pediatric Orthopedic affiliation. Maximum of 60 students. One class a year. Excellent personnel policies. For further particulars apply to Miss E. A. Bietsch, Director of Nursing, Medicine Hat General Hospital, Medicine Hat, Alberta.

Graduate Nurses (2) for 22-bed hospital. Salary: $230 per mo. if B.C. registered, less $40 board, room and laundry. 28 days vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, to Matron, Burns Lake Hospital, Burns Lake, British Columbia.

Registered Nurses for General Staff Duty in 80-bed general hospital. Good personnel policies. Apply Director of Nurses, Parry Sound General Hospital, Parry Sound, Ont.

Supt. of Nurses for 22-bed hospital. State salary. Increments every 6 mos. for 2½ yrs. Living accommodations in separate nurses' residence equipped with automatic heating and hot water supply. 1 mo. holiday after 1 yr. employment. Statutory holidays and cumulative sick leave. Hospital well equipped and constitutes a staff of 4 nurses, 4 aides, combined laboratory and x-ray technician, cook, assistant cook, maid and janitor. No business matters to handle such as bookkeeping, purchasing, etc. Apply to Secretary Manager or Supt. of Nurses, Union Hospital, Hafford, Saskatchewan, in writing or by phone.

Matron for 14-bed hospital. Modern equipment; 1 mo. vacation annually; 8-hr. day. Apply: Supt., Grand Manan Hospital, Grand Manan, New Brunswick.

Registered Nurses (3) for General Duty in 10-bed hospital. Gross salary: $220; 1 mo. holiday & $100 bonus after 1 yr. Maintenance $30; separate nurses' residence. Apply with references to Mrs. Zalla Poilievre, Sec-Treas., Union Hospital, Leoville, Sask.

Evening Supervisor for 328-bed Tuberculosis hospital, carrying active surgery. Hours 3:30 P.M. to 11:30 P.M. For further information contact Director of Nursing, Fort William Sanatorium, Fort William, Ontario.

Nursing Arts Instructor, experienced, preferably with post graduate course. **Supervisor,** 3-11 period of duty. **General Duty Nurses,** 1 with operating room experience. **Medical Records Librarian; Dietitian.** 88-bed hospital. Apply: Supt., Highland View Hospital, Amherst, Nova Scotia.

Cardiac Disability

How does one evaluate disability? The usual method is determination of the patient's functional capacity. There are many valid objections to this. The estimates vary with the observer. They are influenced by superimposed illness or neurosis and refer mainly to physical activity rather than to work capacity. Work capacity is essentially the functional capacity as related to a certain job and is verification of a patient's ability to work on that job. The man with a severe cardiac neurosis superimposed upon a minimal lesion is as unproductive as the patient who is bedridden by heart failure. Classified according to work capacity, they are equal.

Realizing the limitations of subjective evaluation, physicians have sought more tangible means of determining cardiac function. They hoped that this would give them a more accurate index, a more definite yardstick, with which to measure individual patients. All have been impractical and of little prognostic value. At present, despite the many shortcomings of subjective interpretation, the best judgment of the patient's work capacity is careful, intelligent evaluation of the patient on the job by the psychiatrically oriented internist. The appraisal should be made directly at work or in a rehabilitation centre where the type of occupation can be reproduced. The latter, of course, is the ideal situation and leads to a more accurate index.

To rehabilitate a patient who has been disabled for more than two years is discouraging, but the sheltered workshop has been a boon to many of them. It provides a spirit of cooperation, raises his morale, imbues him with some independence, and frequently provides a stimulus for training. We recommend the sheltered workshop for the elderly unskilled laborer and for the severely disabled cardiac, whether the disability be entirely due to organic disease or to a marked, superimposed psychogenic component. For those who cannot be trained and must remain on a permanent basis in the sheltered workshop, at least the small amount of income gained restores the spirit of independence whereby the cardiac may not have to turn to his children or the community for his every need.

— M. C. Becker and J. G. Kaufman in *The Merck Report,* Oct., 1954.

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